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SMALL BUSINESS HEALTH CARE PROBLEMS AND LONG-TERM CARE

HEARING

BEFORE

THE PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION
ON
COMPREHENSIVE HEALTH CARE

ONE HUNDRED FIRST CONGRESS
FIRST SESSION

CLEVELAND, OH

JULY 6, 1989

PART 4

Printed for the use of the Pepper Commission

U.S. GOVERNMENT PRINTING OFFICE
27-747 ⇆ WASHINGTON : 1990

J891-7

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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SMALL BUSINESS HEALTH CARE PROBLEMS AND LONG-TERM CARE

THURSDAY, JULY 6, 1989

The Pepper Commission
U.S. Bipartisan Commission on
Comprehensive Health Care
Washington, DC.

The Commission met, pursuant to notice, at 9:30 a.m., in the Tower Auditorium of the Ameritrust Building, Hon. Mary Rose Oakar (Representative of the Commission), presiding.

Present: Representative Mary Rose Oakar.

Also Present: Edward F. Howard, general counsel; Steven C. Edelstein, Monica E. McFadden, and Philip Shandler, professional staff.

OPENING STATEMENT OF CHAIRMAN MARY ROSE OAKAR

Chairman Oakar. Good morning. How is everybody this morning? Thank you for being here.

Can you hear me? All right. Let's see what we can do about that, because I know mikes are not always great. How's that? Is that better? OK.

The Pepper Commission, which is the U.S. Bipartisan Commission on Comprehensive Health Care, will come to order.

I am delighted to be here on behalf of the Pepper Commission on Comprehensive Health Care, of which I am a member, and I want to thank all of you for taking time to be here. As you know, we have an overflow crowd here, and we're delighted that people feel this is a national priority, which I certainly do. And so, what we're going to try to do is rotate our audiences. We have other rooms where people can be rotated, so we'll try to do that in a real orderly fashion. OK? So, everybody who is here in this room can please stay here. I also want to make announcements, not necessarily for the record; there are ladies' and men's rooms, if you go out the door to the right, all the way down the hall.

I want to, on behalf of the Commission, welcome everybody. Today's hearing is being held under the auspices of the Claude Pepper Commission. Members of the Pepper Commission include Senators Jay Rockefeller, Edward Kennedy, John Heinz, Senator Dave Durenberger, David Pryor, Max Baucus, as well as Congressmen Henry Waxman, Pete Stark, Bill Gradison, Tom Tauke, and myself.

In addition, the three members appointed by the President include Dr. James Davis, Mr. John Cogan, and Mr. James Balog.

We are charged as a commission by the President and Congress to find solutions to a twofold problem. First, the lack of access to comprehensive health care for approximately 37 million Americans, and the second, the lack of long-term care for people of all ages in need, and their families. The current reporting date for our recommendations of our 15-member commission is November 9, 1989.

In addition to a number of briefings and private hearings, today's session is the fourth public hearing held by this Commission. The first hearing was held in Minneapolis, MN, and focused on general health care problems; the second hearing was held in Missoula, MT, and focused on frontier health care; and, the third hearing was hosted yesterday in Cincinnati, and concentrated on large business health care delivery. All of these hearings have been designed to educate the commission members about the many problems faced by Americans of all regions of our country and, I might add, of all people of our country.

The Commission, then, is looking for solutions to the problem of providing comprehensive health care for everyone. The scope of the lack of access to health insurance problem is best illustrated by a few facts, and I think maybe we'll just set the tone in this way. There are 37 million people currently who lack health insurance. This is about 16 percent of the total population, about 18 percent of the population over 65. There are more than 12 million of the uninsured who are children under the age of 18. The highest rate of uninsurance occurs among people aged 18 to 24, and over 30 percent of young adults often employed in entry-level jobs offering no insurance benefits, have no insurance protection at all.

Among the under-age-65 group, almost 88 percent of the uninsured in 1986 were either workers or lived in families of workers. About half of the uninsured or their family heads worked full time.

In 1980, 7.9 percent of the total population of Cuyahoga, Geauga, Lake, and Medina Counties lacked health insurance. That's in 1980. But, in 1987, 213,000 people, or 11.4 percent of the residents of our area, from our counties, lacked health insurance. Compared to 1980, this represents a 44.3-percent increase in the rate of the uninsurance.

Similarly, the statistics surrounding the problem of long-term care delivery are equally devastating. In 1988, the total national nursing home expenditures amounted to more than $38 billion with one-half of that amount coming directly out of the pocket of the patient or the patient's family, or about $23,000 a year to go into a decent nursing home.

After only 13 weeks in a nursing home, 70 percent of elderly Ohioans spent down to the poverty level. For married couples, over one-half are impoverished within 6 months of the time one spouse enters a nursing home, and approximately 70 percent of the community-based long-term care is given by relatives or friends of the impaired person.

As we will see today, this fact has a profound and powerful effect on the lives and the families of long-term care patients. Both of the problems being investigated by the Pepper Commission are important family issues.

The problem of providing long-term care for members of our families, whether for the elderly or for accident and disease victims of any age, ravages the family finances and consumes the time and the energy of the family members.

Perhaps, most importantly, in addition to expending huge sums of money and time for these almost 8 million people receiving these services, long-term care frequently involves a huge drain on the emotional and psychological capacity of the caregivers. And, given the fact that the fastest growing age group in our country are older Americans over 85, which is good news, but that's a problem as well because we do not—we have not planned out for these longer lifespans of our people, and the long-term care problem promises to intensify.

I am sure that our panel of witnesses will confirm these truths. Today's hearing has an additional focus, and we're proud of the individuals who are here today. We are focused also on small businesses, in particular, the very small business with fewer than 25 employees. They face enormous obstacles when attempting to provide health insurance for their employees.

Again, the facts speak loudly of the problem and the need for a cure. Approximately 23 percent of the uninsured are part of a family in which the head of the household is employed by a business with less than 25 employees; 1.6 million businessowners, primarily sole proprietorships, are uninsured, and 55 percent of the firms with fewer than 100 employees offer health care coverage.

When asked about the problems they face, small businessowners cite a number of obstacles, and I'm going to let them do that.

So, I have a concern for the uninsured workers of small businesses. I think we'll see that in our area we might have a role model for other areas across the country, as they have really tried to address the problem, to the best extent possible, and we're proud of that.

In our quest for a solution, this commission is considering a large range of options. As this hearing indicates, we have a strong commitment to listening to the people of our country in order to find a workable solution to these problems, and I think that it would take all Americans, whether they are in the private or the public sector, to cooperate and come to a consensus on what we do about our people in this vital issue.

Before I introduce the first panel, I want to thank Ameritrust for the use of their auditorium and facilities, and the fine cooperation they've given us. We are blessed in greater Cleveland to have sensitive corporations, and I'm very pleased that they were able to accommodate us today.

I also would like to say that this commission was recently named—renamed the Pepper Commission in memory of the late, great Claude Pepper, who was a mentor to many of us. I think Senator Pepper, who on his deathbed literally, instead of thinking of his own ill health, was thinking of the health care of other Americans. He said his unfulfilled dream was to have access to health care for every single American. And, I think it's in his memory that this commission operates, and, certainly, that I think is why we are all here today. He's not going to let us get away with not doing something about this problem; I guarantee it.

I would like to introduce someone who works very hard for the Commission, and is our legal counsel for the Commission, and, Ed, I'd like to ask you if you would, Ed Howard, if you would like to say a few words. Would you like to say a few remarks?

Mr. **Howard**. Very briefly. Thank you, Ms. Oakar. Just to pick up, I'm principally a member of the Commission staff because I was recruited by Claude Pepper, whom I had the honor to serve as general counsel to the House Aging Committee when he was chairman. And, I think it's worth noting that not only in his conversation with Ms. Oakar the week before he died, but as President Bush presented him with the Medal of Freedom in his hospital bed, he didn't say thanks for the visit, he said: "What are you going to do about home care?" And, I hope that we can get some answers both on that and access to come out of this hearing and the other hearings that we are having.

Chairman **Oakar**. Thank you.

Let me thank in advance my staff, who have been working for many, many hours. It's not easy to put together a hearing. And, let me also thank the Commission staff, who have worked very, very hard, and we're delighted that they are here as well. Thank you, Mark, and others, who have worked so hard.

[The prepared statement of Chairman Oakar follows:]

THE PEPPER COMMISSION
THE U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE
OPENING STATEMENT OF
THE HONORABLE MARY ROSE OAKAR
JULY 6, 1989
Cleveland, Ohio

ON BEHALF OF THE PEPPER COMMISSION ON COMPREHENSIVE HEALTH CARE, OF WHICH I AM A MEMBER, I WANT TO THANK YOU FOR TAKING TIME FROM YOUR BUSY SCHEDULES TO ATTEND THIS IMPORTANT HEARING.

TODAY'S HEARING IS BEING HELD UNDER THE AUSPICES OF THE PEPPER COMMISSION. MEMBERS OF THE PEPPER COMMISSION INCLUDE: SENATORS JAY ROCKEFELLER, EDWARD KENNEDY, JOHN HEINZ, DAVID DURENBERGER, DAVID PRYOR, AND MAX BAUCUS AS WELL AS CONGRESSMEN HENRY WAXMAN, PETE STARK, BILL GRADISON, TOM TAUKE AND ME. IN ADDITION, THE THREE MEMBERS APPOINTED BY THE PRESIDENT INCLUDE DR. JAMES DAVIS, MR. JAMES COGAN AND MR. JAMES BAYLOG.

WE ARE CHARGED BY THE PRESIDENT AND CONGRESS TO FIND SOLUTIONS TO A TWO-FOLD PROBLEM: FIRST IS THE LACK OF ACCESS TO COMPREHENSIVE HEALTH CARE FOR APPROXIMATELY 37 MILLION AMERICANS AND THE SECOND IS THE LACK OF LONG-TERM CARE FOR PEOPLE OF ALL AGES IN NEED AND THEIR FAMILIES. THE CURRENT REPORTING DATE FOR OUR RECOMMENDATIONS IS NOVEMBER 9, 1989.

IN ADDITION TO A NUMBER OF BRIEFINGS AND PRIVATE HEARINGS, TODAY'S SESSION IS THE FOURTH PUBLIC HEARING HELD BY THE COMMISSION. THE FIRST HEARING WAS HELD IN MINNEAPOLIS, MINNESOTA

AND FOCUSED ON GENERAL HEALTH CARE PROBLEMS; THE SECOND HEARING WAS HELD IN MISSOULA, MONTANA AND FOCUSED ON FRONTIER HEALTH CARE; THE THIRD HEARING WAS HOSTED YESTERDAY IN CINCINNATI AND CONCENTRATED ON LARGE BUSINESS HEALTH CARE DELIVERY. ALL OF THESE HEARINGS HAVE BEEN DESIGNED TO EDUCATE THE COMMISSION MEMBERS ABOUT THE MANY PROBLEMS FACED BY AMERICANS OF ALL REGIONS OF THE NATION.

THE COMMISSION, THEN, IS LOOKING FOR SOLUTIONS TO THE PROBLEM OF PROVIDING COMPREHENSIVE HEALTH CARE FOR EVERYONE. THE SCOPE OF A LACK OF ACCESS TO HEALTH INSURANCE PROBLEM IS BEST ILLUSTRATED BY THE FOLLOWING FACTS:

1. OVER 37 MILLION PEOPLE CURRENTLY LACK HEALTH INSURANCE. THIS IS ABOUT 16% OF THE TOTAL POPULATION AND ABOUT 18% OF THE POPULATION OVER AGE 65.

2. OVER 12 MILLION OF THE UNINSURED ARE CHILDREN UNDER THE AGE OF 18.

3. THE HIGHEST RATE OF "UNINSURANCE" OCCURS AMONG PEOPLE AGE 18-24. OVER 30% OF YOUNG ADULTS -- OFTEN EMPLOYED IN ENTRY-LEVEL JOBS OFFERING NO INSURANCE BENEFITS -- HAVE NO INSURANCE PROTECTION AT ALL.

4. AMONG THE UNDER-AGE 65 AGE GROUP, ALMOST 88% OF THE

UNINSURED IN 1986 WERE EITHER WORKERS OR LIVED IN FAMILIES OF WORKERS. ABOUT HALF OF THE UNINSURED (OR THEIR FAMILY HEADS) WORKED FULL TIME.

5. IN 1980, 7.9% OF THE TOTAL POPULATION OF CUYAHOGA, GEAUGA, LAKE AND MEDINA COUNTIES LACKED HEALTH INSURANCE.

6. IN 1987, 213,000 PEOPLE OR 11.4% OF THE RESIDENTS OF THESE FOUR OHIO COUNTIES LACKED HEALTH INSURANCE. COMPARED TO 1980, THIS REPRESENTS A 44.3% INCREASE IN THE RATE OF UNINSURANCE.

SIMILARLY, THE STATISTICS SURROUNDING THE PROBLEM OF LONG-TERM CARE DELIVERY ARE EQUALLY DEVASTATING:

1. IN 1988, TOTAL NATIONAL NURSING HOME EXPENDITURES AMOUNTED TO OVER $38 BILLION WITH ONE-HALF OF THAT AMOUNT COMING DIRECTLY OUT OF THE POCKET OF THE PATIENT OR THE PATIENT'S FAMILY;

2. AFTER ONLY 13 WEEKS IN A NURSING HOME, 70% OF ELDERLY OHIOANS SPEND DOWN TO THE POVERTY LEVEL;

3. FOR MARRIED COUPLES, OVER ONE-HALF ARE IMPOVERISHED WITHIN SIX MONTHS OF THE TIME ONE SPOUSE ENTERS A NURSING HOME.

4. APPROXIMATELY 70% OF COMMUNITY-BASED LONG-TERM CARE IS GIVEN BY RELATIVES OR FRIENDS OF THE IMPAIRED PERSON. AS WE WILL SEE TODAY, THIS FACT HAS A PROFOUND AND POWERFUL EFFECT ON THE LIVES OF THE FAMILIES OF LONG-TERM CARE PATIENTS.

BOTH OF THE PROBLEMS BEING INVESTIGATED BY THE PEPPER COMMISSION ARE IMPORTANT **FAMILY ISSUES**. FOR EXAMPLE, THE PROBLEM OF PROVIDING LONG-TERM CARE FOR MEMBERS OF OUR FAMILIES-- WHETHER FOR THE ELDERLY OR FOR ACCIDENT AND DISEASE VICTIMS OF ANY AGE -- RAVAGES FAMILY FINANCES AND CONSUMES THE TIME OF FAMILY MEMBERS. PERHAPS MOST IMPORTANTLY, IN ADDITION TO EXPENDING HUGE SUMS OF MONEY AND TIME FOR THE 7.5 MILLION AMERICANS RECEIVING THESE SERVICES, LONG-TERM CARE FREQUENTLY INVOLVES A HUGE DRAIN ON THE **EMOTIONAL AND PSYCHOLOGICAL** CAPACITIES OF THE CAREGIVERS. AND, GIVEN THE FACT THAT THE FASTEST GROWING AGE GROUP IN OUR COUNTRY IS OLDER AMERICANS OVER AGE 85, AND THAT WE CAN CONTINUE TO EXPECT LONGER LIFESPANS FOR OUR PEOPLE, THE LONG-TERM CARE PROBLEM PROMISES TO INTENSIFY. I AM SURE OUR PANEL OF WITNESSES WILL CONFIRM THESE TRUTHS.

TODAY'S HEARING HAS AN ADDITIONAL FOCUS: SMALL BUSINESSES-- IN PARTICULAR THE VERY SMALL BUSINESSES WITH FEWER THAN 25 EMPLOYEES -- FACE ENORMOUS OBSTACLES WHEN ATTEMPTING TO PROVIDE HEALTH INSURANCE FOR THEIR EMPLOYEES. AGAIN, THE FACTS SPEAK LOUDLY OF THE PROBLEM AND THE NEED FOR A CURE:

- APPROXIMATELY 23% OF THE UNINSURED ARE PART OF A FAMILY IN WHICH THE HEAD OF THE HOUSEHOLD IS EMPLOYED BY A BUSINESS WITH LESS THAN 25 EMPLOYEES.

- 1.6 MILLION **BUSINESS OWNERS** (PRIMARILY SOLE PROPRIETORSHIPS) ARE UNINSURED.

- 55% OF FIRMS WITH FEWER THAN 100 EMPLOYEES OFFER HEALTH CARE COVERAGE;

- THREE-FOURTHS OF THE 8.2 MILLION UNINSURED PRIVATELY EMPLOYED WORKERS -- OVER 6 MILLION -- ARE EMPLOYED BY A COMPANY WITH FEWER THAN 500 EMPLOYEES.

WHEN ASKED ABOUT THE PROBLEMS THEY FACE, SMALL BUSINESS OWNERS NAME SEVERAL OBSTACLES TO THEIR ATTEMPTS TO PROVIDE HEALTH CARE FOR THEIR EMPLOYEES:

1. GIVEN THE SMALL NUMBER OF EMPLOYEES, SMALL BUSINESSES OFTEN CANNOT FIND COVERAGE FROM PRIVATE INSURERS. SIMPLY SPEAKING, THE SIZE OF THE POOL THEY WANT TO INSURE IS TOO SMALL FOR ADEQUATE RISK ASSURANCE FOR THE INSURING COMPANY;

2. ANOTHER PROBLEM RELATED TO THE FIRST PROBLEM IS MEDICAL UNDERWRITING. THIS IS THE PROCESS THAT "WEEDS OUT" EMPLOYEES FROM COVERAGE BECAUSE OF CURRENT OR PRIOR HEALTH PROBLEMS;

3. EMPLOYEE TURNOVER IS HIGHER IN SMALL BUSINESSES, MAKING ADMINISTRATION OF A HEALTH PROGRAM VERY DIFFICULT;

4. LASTLY, A LACK OF SUFFICIENT PROFIT IS ALSO A MAJOR OBSTACLE FOR MANY BUSINESSES. MANY OPERATORS SIMPLY CANNOT AFFORD THE EXTRA COST OF INSURING THEIR EMPLOYEES.

MY CONCERN FOR THE UNINSURED WORKERS OF SMALL BUSINESSES IS ACUTE BECAUSE VERY SMALL ENTERPRISES OFTEN POSSESS, AS A PERCENTAGE OF THEIR TOTAL WORK FORCE, MORE WOMEN AND MINORITIES THAN LARGER ENTERPRISES. CONSEQUENTLY, WHEN COUPLED WITH THE OTHER PROBLEMS THESE POPULATIONS FACE, THEIR PLIGHT BECOMES EVEN MORE DRAMATIC. WE WILL BE HEARING FROM OUR OWN SMALL BUSINESS ASSOCIATION TO LEARN HOW THEY HAVE ADDRESSED THE PROBLEM OF PROVIDING HEALTH CARE FOR THEIR EMPLOYEES.

IN ITS QUEST FOR SOLUTIONS, THE COMMISSION IS CONSIDERING A LARGE RANGE OF OPTIONS. AS THIS HEARING INDICATES, WE HAVE A STRONG COMMITMENT TO LISTENING TO THE PEOPLE OF OUR COUNTRY IN ORDER TO FIND A WORKABLE SOLUTION TO THESE PROBLEMS.

BEFORE I INTRODUCE OUR FIRST PANEL, I WANT TO THANK AMERITRUST FOR THE USE OF THEIR AUDITORIUM AND THE COOPERATION THEY HAVE GIVEN TO ALL OF US.

THANK YOU.

Chairman **Oakar**. Our first panel is our small business panel, and we're delighted to have Doris Freedman from the Small Business Administration, who will present some interesting facts about the role of small business. Next we have David Helms, who is joining her, who is with the Robert Wood Johnson Foundation, and we'll start with them and John Galles as well, who is with the National Small Business United organization. We're delighted Mr. Galles is here since this is a trade association for small business.

And then, we will next hear from John Polk and Brad Roller. I'll be introducing you in a second.

So, why don't we begin. I'm going to try to limit everybody, so that we can have some time for questions. So whenever, if you can summarize your remarks or put everything in the record, but we cannot exceed, you know, 10 minutes each, so that we can fit everybody in, because we have all kinds of individuals who will be testifying as well, and I think we want to make sure everybody has a chance.

All right. Doris, thank you very much for being here, and if you would like to begin. You are going to have to hold that microphone pretty close, I suspect.

STATEMENT OF DORIS FREEDMAN, DIRECTOR OF INTERAGENCY POLICY, OFFICE OF ADVOCACY, SMALL BUSINESS ADMINISTRATION

Ms. **Freedman**. Thank you very much, Ms. Oakar. I'm glad to be here.

As you certainly well know, health insurance is a very big problem for small business. They are concerned about it, and are anxious to provide health care coverage to their workers.

Several trends are occurring right now, which makes health care an even bigger concern to small business than it has been in the past. First of all, the cost of health care is escalating, that's no surprise to anybody in this room. Second, the demographics are changing. Workers are now older than they used to be and more interested in receiving health care coverage. And, third, the size of the uninsured population has grown. There's a high percentage of working uninsured.

I brought some charts with me that will demonstrate this point. If you look at this chart to my far right, it breaks down who does not have insurance. We estimate that as many as 75 percent of all people who do not have health insurance are in some way connected to an employee of a small business. Either they are employed by the small business or they are a young or older dependent of somebody who is employed in a small business. Also, there's a large number of businessowners themselves who have no coverage.

What I would like to do today is present a picture of the small business, and to show who does have coverage, who doesn't have coverage, and, perhaps, give some explanations of why more coverage isn't available.

I want to add one thing, in addition to the data that I'm presenting today, and I do have a lot of facts and figures, we are doing some further studies to update some of the information that I will be talking about. One of the studies that we're doing is based on a survey of employees, and one is based on a survey of employers.

The first study is based on a survey of employees, and it's going to update some of the figures on this chart. The one probably of the most concern is aimed at getting more information on the under-16 population, to see why they aren't insured and what percentage of premiums are being covered for them.

The second study is a survey of employers, and that will be updating more general information about what businesses do and don't have insurance.

First of all, I want to talk about some characteristics of the small business work force. Small business employees are a very different mix than those of large companies. They are more likely to be either younger workers or older workers, and a larger share of them are women and part-time workers. In addition, they tend to move around more and are more likely to be reentering the work force after a long absence.

The makeup of the work force is important to understand, because small businesses are more labor intensive than large businesses. They typically depend more on people than on machinery.

Small firms have concentrations of workers whose age, gender, and work patterns are characterized by above-average turnover and this affects health care coverage.

Small firms, more than large firms, tend to hire younger and older workers. Two-thirds of all entry level workers are hired by small firms, and 66 percent of all workers, age 16 to 24, are employed by small firms. In 1983, which is the latest data we have, small firms employed 80 percent of the elderly workers.

Women are more likely to work in small firms than in large firms. Almost two-thirds of women workers are employed in small firms.

Small firms also have higher labor turnover rates than large firms, in part, because of the characteristics of the workers themselves, and also, small businesses often have a flexible work pattern that's more in tune to these workers. They have more part-time employees and more part-time jobs. About 27 percent of workers in small firms move every year, compared to 15 percent in large firms.

Part-time employees also make up a significant part of the small business work force. Part-time employees, working less than 35 hours per week, comprise almost 30 percent of the small firm work force compared to about 15 percent in large firms.

Each of these characteristics has an effect on either the cost of health care coverage or the desire for workers to have health insurance. Part-time, seasonal, and older workers, as well as workers who shift jobs more frequently, tend to increase the cost of health insurance. Younger workers tend to be less interested in health insurance than older workers and often opt for higher wages. On the other hand, women workers, especially those who are heads of households, are very concerned with health care coverage.

I want to give you some information on both the cost and coverage of health care for small businesses. First I want to talk about some of the costs. Health care costs have risen dramatically in recent years. Health expenditures in the United States have increased from $42 billion in 1965, to $540 billion in 1988. In 1986, health care costs averaged 8 percent of payroll for an outlay of almost $1,500 per employee.

As is true for all fringe benefits, the prevalence of health care coverage increases with firm size. If you look at the chart directly behind me, you'll see this quite dramatically. In firms with 1 to 9 employees, about 46 percent of the firms offer health care coverage. In the 10 to 24 range it's 78 percent. When you get to 25 to 99, it's about 92 percent. When you get to firms with more than 500 employees, it's nearly universal.

The next chart I have here gives a picture of which workers do not have health insurance. Our estimates indicate that there are a total of 8.2 million people who are employed that do not have insurance. Of that, you'll see that more than 47 percent are in firms with 1 to 24 workers.

The 8.2 million roughly breaks down to 6.1 million are in firms with less than 500 employees, while 2.1 million are in firms with over 500 employees. If the 10 percent of businessowners without coverage are added into the figure, the 47 percent rises to about 60 percent.

Data show that health care premiums for small companies run 10 to 40 percent higher than for large firms. This is primarily attributable to medical underwriting and administration costs. Administrative costs are higher because the insurance company, rather than the employer's inhouse employees, must absorb most of the administration function of the plans. It is much more costly for an insurance company to cover 10 employees in 100 firms than 1,000 employees in 1 large firm.

Small firms are also less likely to self-insure. While at least 40 percent of firms with more than 500 employees are self-insured, only 5 percent of firms with fewer than 100 employees use this system.

Small firm employers pay average monthly premiums about 10 percent higher for single coverage than large firms, $87 compared with $80. For family coverage, the premiums are more than 20 percent higher, $183 compared with $152. For plans for fewer than 25 employees, companies are frequently required to buy a set package that cannot be altered, which includes benefits mandated by States to be offered in insurance policies. That is a problem that the self-insured do not have.

Small plans may also be relatively more expensive for small employers, because they are more likely to pay all of the health care premium costs rather than require some employee contribution. Small employers may pay the full premium because they find it less of an administrative burden to do so or because it may have fewer fringe benefits or because they employ family members and want to see that they have coverage.

I want to touch on some reasons why firms do not—small firms do not offer health insurance. First of all, as I said, they pay a higher rate, they often don't receive the same tax benefits as larger firms do, because sole proprietors, in large part, are not insured, and they have a higher turnover rate. But, not only the size of the business affects the health care coverage, approximately 65 percent of all workers whose employers do not sponsor health plans are in firms with fewer than 10 employees. So, it's not only size, but also the industry—41 percent of all workers whose employers do not sponsor plans are in the retail industry; 40 percent of all firms that do not sponsor health plans are retail trade firms with fewer than 10 employees.

The legal form of the business can also affect health care coverage. As you can see from these charts, the firms offering the lowest coverage are sole proprietorships, subchapter S corporations are somewhat higher, and chapter C corporations offer the highest. However, the overriding reason that small employers do not offer health insurance is they can't afford it. We did a followup study to our basic study that we have done and are reporting on it now. It was a survey of those firms that did not offer health insurance in one to nine categories.

In 2 years, most of the firms still do not offer health insurance, and the ones that did were those that showed the greatest profits, and the ones that showed the greatest increase in the number of employees.

I hope this information has been useful to you, and I'll be happy to answer any questions.

[The prepared statement of Ms. Freedman follows:]

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

OFFICE OF CHIEF COUNSEL FOR ADVOCACY

STATEMENT

OF

DORIS S. FREEDMAN

DIRECTOR, INTERAGENCY POLICY

OFFICE OF ADVOCACY

U.S. SMALL BUSINESS ADMINISTRATION

BEFORE THE

U.S. BIPARTISAN COMMISSION ON

COMPREHENSIVE HEALTH CARE

CLEVELAND, OHIO

JULY 6, 1989

Health benefits are among the most common fringe benefits offered by employers. In order to attract and retain employees, employers strive to establish and maintain health care plans responsive to the needs of workers. The increased attention to health care and its importance to small employers is exemplified by the ranking of this issue as second among all issues voted upon by the 1800 small business delegates to the 1986 White House Conference on Small Business. Most recently, the amount of concern and activity during the public discussion of Internal Revenue Code Section 89 by small businesses and their representative associations reaffirms the significance of health benefits to employers.

The particular attributes of small business and its workforce, as well as small business health care coverage, should be foremost in the deliberations of this Commission as it examines expanding access to health care for the uninsured. We are pleased to testify before this Commission to present this picture.

In addition to the data presented today, our office is presently examining the most recent data from the Current Population Survey (CPS) March and May Supplements (1988). We are preparing material from the CPS for 1989 Small Business and the American Economy, which will include data by size of firm on health care coverage for children under age 15, whether the premium or part of the premium is paid by the employer or union, and other data on the offering, eligibility, and coverage of health insurance. We expect preliminary data by the end of July.

In addition, we have contracted for a report to update our 1986 study entitled Health Care Coverage and Costs in Small and Large Firms. A comparison of the data from these two studies should be helpful to the Commission.

Worker Characteristics

Small business employees are a different mix than those of large companies. They are more likely to be younger or older than the average worker, and a larger share of them are women and part-time workers. In addition, they tend to move around more and are more likely to be reentering the workplace after an absence. The make-up of the workforce is important to understand because small firms are more labor intensive than large companies; they typically depend more on people than machines.[1] Labor intensive industries, such as retail trades, are likely to be dominated by small firms.[2] These firms have concentrations of workers whose age, gender, and work patterns not only are characterized by above average turnover and a weaker attachment to the labor market, but also affect health care coverage.

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[1] See generally "The Role of Small Business in Efficient Resource Allocation," The State of Small Business: A Report of the President, U.S. Small Business Administration, (Washington, D.C., Government Printing Office, 1987), Chapter 3 [hereinafter 1987 President's Report.]

Small firms, more than large firms, tend to hire younger and older workers. Because of the shrinking teenage population and labor force between 1979 and 1983, the proportion of younger workers in firms of all sizes dropped. However, the decline in younger workers was greater in large than in small firms. In 1983, small firms employed 66 percent of the younger workers, an increase of more than 3 percentage points from the 1979 level.[3] Two thirds of all entry level workers are hired by small firms, and 66 percent of all workers ages 16 to 24 are employed by small firms.[4]

In 1983, small firms employed 80 percent of the elderly workers. I must note that the 1982 amendments to the Age Discrimination Act, which require firms with 20 or more employees offering health insurance be the primary payers, may have affected both employment numbers for this group and health insurance premiums for employers for whom they work.

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[2] The State of Small Business: A Report of the President, U.S. Small Business Administration, (Washington, D.C., Government Printing Office, 1988), Table A-2 [hereinafter 1988 President's Report.]

[3] "Minority-Owned Business," The State of Small Business: A Report of the President, U.S. Small Business Administration, (Washington, D.C., General Printing Office, 1986), pp 230-31, [hereinafter 1986 President's Report.]

[4] The State of Small Business: A Report of the President, U.S. Small Business Administration, (Washington, D.C., Government Printing Office, 1989) p. 33.

Women were more likely to work in small firms than in large firms in both 1979 and 1983; almost two-thirds of women workers are employed by small firms. In 1983, a higher proportion of female than of male wage-and-salary earners were employed in firms with fewer than 500 employees -- 59 percent compared to 57 percent.[5]

The pattern of black and Hispanic workers differs substantially from each other. According to our 1983 data, black workers represented 6.7 percent of all wage-and-salary workers in firms with fewer than 500 employees. Due in part to the shift of black women from small to large firms, the proportion of blacks increased in large firms from 7.9 percent in 1979 to 8.8 percent in 1983. Increases in the Hispanic wage-and-salary workers have been highest in firms with fewer than 25 employees and in large firms with 500 or more workers.[6]

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[5] "1986 President's Report, pp. 230-33.M.

[6] Ibid., p.235.

Small firms also have higher labor turnover rates than large firms, in part because of the characteristics of the workers they hire and the opportunities that they are able to provide for flexible work conditions, including more part-time, part-year jobs. About 27 percent of workers in small firms move every year compared with 15 percent in large firms.[7]

Part-time employees also make up a significant part of the small business workforce. Part-time employees working less than 35 hours per week comprise almost 30 percent of the small firm workforce, compared with about 16 percent in large firms.[8]

Each of these characteristics has an effect on either the cost of health care coverage or the desire for workers to have health insurance. Part-time and seasonal workers, as well as workers who shift jobs more frequently, tend to increase the cost of health insurance. Younger workers tend to be less interested in health insurance than older workers; younger workers often opt for higher wages. On the other hand, women workers, especially those who are heads of households, are very concerned with health care coverage.

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[7] Berkeley Planning Associates, "Labor Turnover and Worker Mobility in Small and Large Firms," prepared for the U.S. Small Business Administration, Office of Advocacy, under Award No. SBA-2092-AER-87, December, 1988), p. 36.

[8] 1986 President's Report, p. 245.

Health Benefits in Small Firms

A. Costs of Benefits. Health care costs have risen dramatically in recent years. Health expenditures in the U.S. have increased from $42 billion in 1965 to $425 billion in 1985 to $500 billion in 1987. In 1986, health care costs averaged 8 percent of payroll for an outlay of almost $1500 per employee.[9]

As is true for all fringe benefits, the prevalence of health care coverage increases with firm size. (Attachment A) The greatest gaps are between firms with fewer than 10 or fewer than 25 employees and those employing more than 20 workers. More than 47 percent of all uninsured workers are in firms with 1-24 employees.[10] (Attachment B) If the 10 percent of business owners without coverage were added in, the figure rises to 60 percent. In firms with more than 24 employees, more than 90 percent of employers within each size category offer health benefits to workers.[11]

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[9] A study prepared by The Wyatt Company, 1986.

[10] U.S. Small Business Administration, Office of Advocacy, Census SIPP Data, 1984.

[11] Health Care Coverage and Costs in Small and Large Firms, ICF, Inc., prepared for the Office of Advocacy, U.S. Small Business Administration, April 15, 1987, p. III-6.)

Data show that health care premiums for small companies run 10 to 40 percent higher than for large firms.[12] This is primarily attributable to medical underwriting[13] and administration costs. When there is a smaller number of people over whom to spread the risk, as small firms, one high cost illness has a much greater affect on the entire company's plan.

Administrative costs are also higher because the insurance company, rather than the employer's in-house employees, must absorb much of the administrative functions of the plan. It is much more costly for an insurance company to cover 10 employees in 100 firms than 1000 employees in one large firm. Small firms are also less likely to self-insure. While at least 40 percent of firms with more than 500 employees are self-insured, only 5 percent of firms with fewer than 100 employees use this system.

Premiums are also costlier for employers in small firms. Small firm employers pay average monthly premiums about 10 percent higher for single coverage than large firm employers --

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[12] 1987 President's Report, p. 134.

[13] Very small firms, usually with fewer than 20 employees, and individuals are medically underwritten, which is an expensive process. Medical underwriting assesses the health status of each individual to determine whether or not the firm will be accepted for coverage and in some cases whether certain employees or illnesses are excluded from coverage. This differs from group coverage where rating is based on the group as a whole. Very different criteria are used to underwrite individuals or small groups than are used for underwriting large groups.

$87 compared with $80. For family coverage the premiums are more than 20 percent higher -- $183 compared with $152.[14] For plans for fewer than under 25 employees, companies are frequently required to buy a set package that cannot be altered, which includes benefits mandated by states to be offered in insurance policies.

B. Coverage of Workers by Small Employers. Small plans may also be relatively more expensive for very small employers because they are more likely to pay all health premium costs rather than require some employee contribution. Seventy percent of firms with fewer than 100 workers pay all of their employees' single premium contracts, compared to 61 percent of firms with 100 or more workers. On average, the smallest firms pay 89 percent of single premiums and 87 percent of family premiums, while firms with more than 500 workers pay 87 percent of single premiums and only 67 percent of family premiums.[15] Small employers may pay the full premium because they find it less of an administrative headache to do so, or because they are making up for fewer fringe benefits overall, i.e. pensions. It may also be due to the fact that they employ family members.

While it is true that about three-quarters of the working uninsured and their dependents are connected to small firms, our studies show that small firms with health benefits more frequently offer coverage to all their employees than do large firms. (Attachment C) About 44 percent of small firms with fewer than 100 employees versus less than 25 percent of large firms (more than 100 employees) indicate that all employees are eligible for health insurance coverage.[16]

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[14] ICF IV-10.

[15] ICF at IV-a-13.

Part-time and seasonal workers in small firms are also more likely to have the opportunity for coverage. In large firms, 76 percent of part-time workers and 59 percent of seasonal and temporary workers are excluded from health coverage compared with 68 percent and 49 percent, respectively, in small firms.[17] Very small firms with 10 or fewer employees also tend to have more generous benefits than businesses of 11-24 workers. This may be because many of these companies employ family members, and therefore, prefer broader coverage.

Why Firms Do Not Offer Health Insurance

Small firms are less likely to offer health benefits for a variety of reasons:

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[16] ICF, III-18.

[17] ICF, III-16.

- Smaller groups face higher per capita premium costs because risk is higher in small groups;
- Smaller groups often do not benefit to the same extent as larger firms from tax advantages associated with offering health insurance;
- The fixed costs associated with choosing and administering health plan are higher;
- Higher employee turnover rates and greater use of part-time and seasonal employees also increases administrative fees for small firms relative to large firms.

Both size of firm and industry category affect health care coverage. Approximately 65 percent of the all workers whose employers do not sponsor plans are in firms with fewer than 10 employees.[18] The bulk of companies without coverage are in the retail trade and construction industries. Forty-one percent of all workers whose employers do not sponsor plans are in the retail industry. The service industry accounts for 19 percent of workers in firms not offering health insurance. Forty percent of all firms which do not sponsor health plans are retail trade firms with fewer than 10 employees. Data also indicate that workers in certain businesses are significantly more likely to be without coverage. These industries are characterized by lower and variable profits, high turnover, and an inordinate number of part-time, seasonal, or young workers.

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[18] ICF, p. ES3.

The legal form of a business also can affect health care coverage. One can importune that the connection between legal form and health insurance coverage is partially based on tax incentives, and that an equalization of tax incentives among sole proprietorships, partnerships, Subchapter S and other corporate forms is important for broadening access to health care coverage through employers. A sole proprietor cannot take the full cost of his or her health insurance as a deduction; unlike corporate officers and owners the deduction is limited to 25 percent.

As far as legal form, approximately 29 percent of sole proprietorships offer coverage, compared to 49 percent of Subchapter S corporations, and 77 percent of corporations.[19] (Attachment D) Even in the smallest size category of 1-9 employees, corporations are more than twice as likely to provide coverage than in a sole proprietorship or a Subchapter S corporation.

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[19] 1987 President's Report, pp. 140-50.

However, the overriding reason small employers do not offer health insurance is that they cannot afford to do so. In 1988 a follow-up to our April 1987 ICF study was conducted on the original respondent firms in the 1-9 category who indicated they did not offer health insurance in 1986.

- Of the original firms, 18 percent have started to offer insurance, and 82 percent still do not offer insurance;
- For those firms still not offering insurance, 43 percent said they could not afford insurance and 34 percent said their employees were covered elsewhere;
- Of the firms that started to offer health insurance, there were more full time workers than firms without health coverage, and the average revenue was $845,000, compared to $232,000 for firms not offering insurance;
- The average payroll and salary were higher, with full time workers at $15,600 for insured firms, and $7,400 for uninsured firms;
- Firms starting to offer insurance experienced an average

increase in revenues of $186,000 over the past two years, and an average increase in workers of four. Those not offering insurance saw a $39,000 increase in revenues and an increase in workers of one;

- If the uninsured firms in the sample paid $80 per month on an average for health insurance premiums, the premiums would equal 19 percent of the uninsured firms' profits or owners' salary. If the firms paid $125 per month, the premiums would equal 30 percent of profits or owners' salary.[20]

While offering lower wages and fewer benefits, small firms are more likely to tailor their wages and fringe benefits they offer to the type of workforce they employ. Young workers, older workers, and secondary earners are more likely to opt for higher wages in lieu of pension, health and other fringe benefits either because they do not want coverage or they are covered elsewhere. Approximately 14 percent of eligible workers in small firms turn down coverage in their firms' plans, compared to 7 percent in the larger companies.[21]

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[20] ICF/Lewin, Increases in Health Insurance Coverage in Small Firms 1986-88, National Association of the Self-Employed, June 1988.

[21] ICF, p. III-23.

Many of these workers are secondary workers who may be covered by a spouse's plan. Younger workers, who are generally very healthy, frequently opt for higher wages over employee benefits. Once these workers are eliminated from the employer's pool, the average cost per employee for health insurance could be considerably higher. The large number of older workers who work in small business, on a per capita basis, spend almost three times as much as the general population on health care.

Mandating Universal Coverage Through Employers

Legislation proposing universal health care coverage through employers has been submitted in the last two congressional sessions, and Massachusetts has adopted a universal coverage program. The price tag for these programs falls to employers for payment, and impinges on or reduces the flexibility in the employer-employee relationship that will be critical in the next century to meet workforce needs. The Congressional proposal for universal coverage also contains an inflexible set of benefits an employer would be mandated to offer without realistic cost containment features, which, in this era of rising health care costs, cannot be ignored.

Mandating universal coverage requires regulating parts of the health care delivery system. This extends beyond simply requiring the employers to extend coverage to their employees. These delicate interrelationships among the various sectors involved in the financing and delivery of health care, superimposed on a federal scheme that addresses financing only, will significantly affect the cost of health care for employers. One only has to look to Massachusetts, which has had difficulty in balancing state commitments to its new universal coverage requirements and state budget constraints. The Massachusetts plan demonstrates the difficulties in imposing the mandated coverage program on employers.

Recommendations

After careful examination of the nature of the kinds of firms that lack coverage and the characteristics of medically uninsured workers, the following voluntary steps should be considered:

1. Encouraging the private insurance industry to develop and effectively market health insurance plans for small employers that cost significantly less than plans presently available to employers, including catastrophic plans;

2. Expanding the 25 percent Federal and state tax deduction for health premiums for unincorporated business owners to 100

percent for purposes of both tax equity and increased coverage;

3. Making available a Medicaid buy-in for coverage of low-income workers;

4. Federal preemption of all state mandated benefits so that small businesses could choose more cost-effective plans;

5. Encouraging multiple employer trusts in order to reduce administrative costs;

6. Fostering government and private sector education programs on the availability and costs of health insurance for small employers and ways in which they can keep these costs down.

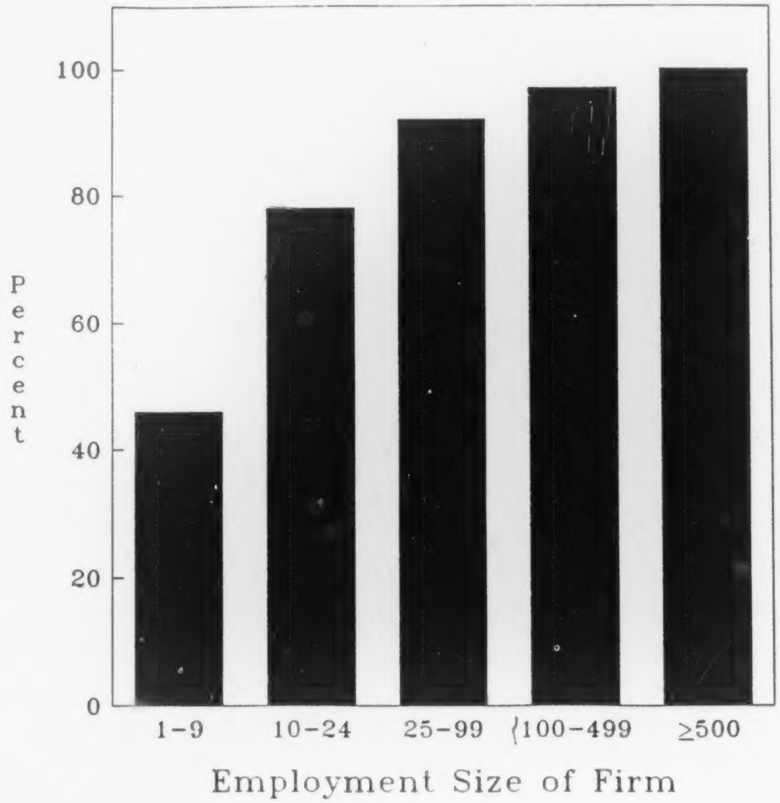
In December 1988, the Office of Advocacy issued a report on the variety of state and local initiatives expanding health care coverage in this country. Those approaches are now being more fully developed; enough time should be given to gauge the effectiveness of these initiatives. Our office is currently updating this report to reflect the new and broadened state programs.

There is no question that small employers will have to address the access to health care issue, partly due to the changes in the labor supply. The labor pool will be more restricted by the year 2000, and, with the rate of growth in the labor pool declining, small business will have to be stronger competitors to attract workers.

In addition, the internationalization of the American economy is causing small businesses to shift from the traditionally stable U.S. economy to more volatile international markets. It is important that to meet the changes in the year 2000, small employers' flexibility not be unduly restricted.

ATTACHMENT A

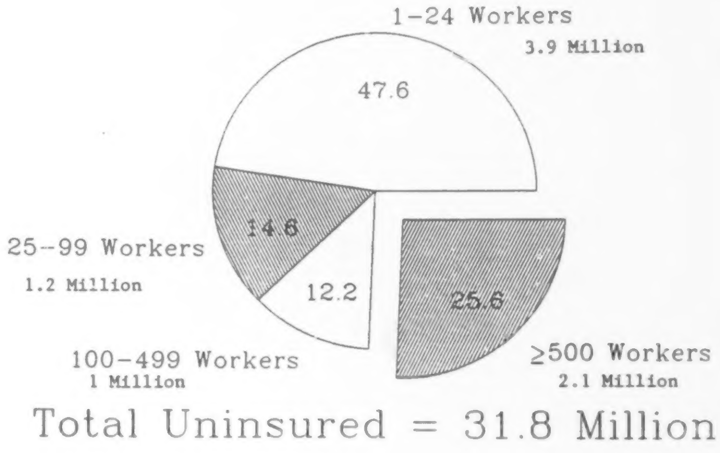
Percentage of Firms that Offer Health Benefits



Source: U.S. Small Business Administration, Office of Advocacy, ICF Report (1986)

ATTACHMENT B

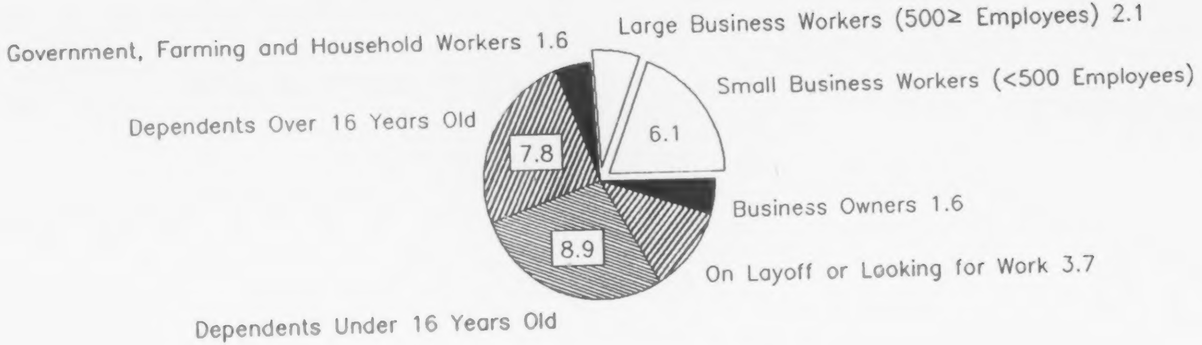
Workers Not Covered by Health Insurance by Firm Size, 1984



Source: U.S. Small Business Administration, Office of Advocacy, Census SIPP Data (1984)

ATTACHMENT C

Population Without Health Insurance (Millions)

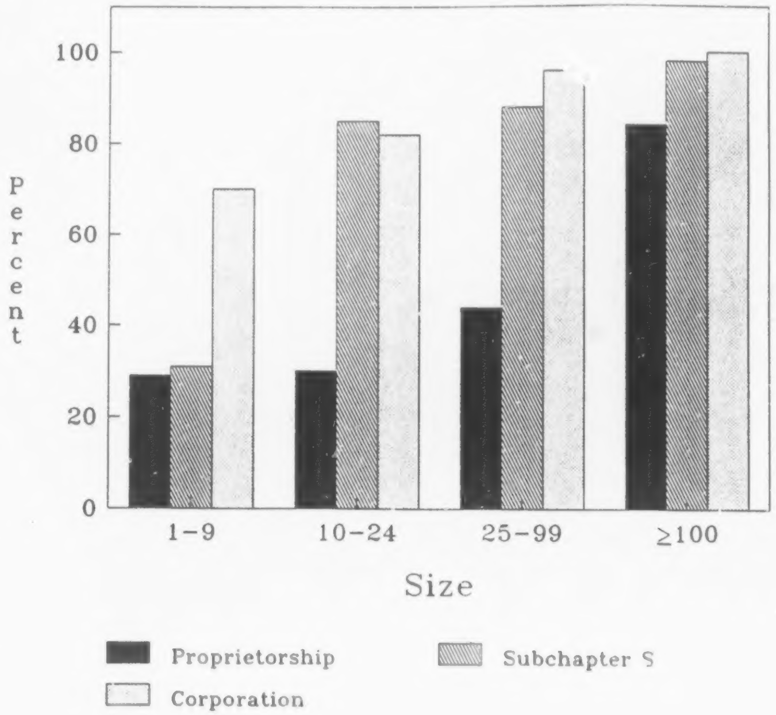


Total Uninsured = 31.8 Million

Source: U.S. SBA, Office of Advocacy, Census SIPP Data, 1984

ATTACHMENT D

Firms that Sponsor Health Plans by Employment Size and Form of Ownership, 1985



Source: U.S. Small Business
Administration, Office of Advocacy,
ICF Report (1986)

Chairman **Oakar**. Well, it is. It gives us an interesting overview of the problems of small business people trying to provide insurance. We are happy to have it.

Our next witness is David Helms, who is the senior consultant for the uninsured program at Robert Wood Johnson Foundation. David, thank you for being here.

STATEMENT OF W. DAVID HELMS, Ph.D., EXECUTIVE DIRECTOR, ALPHA CENTER AND PROGRAM DIRECTOR, HEALTH CARE FOR THE UNINSURED PROGRAM, ROBERT WOOD JOHNSON FOUNDATION

Mr. **Helms**. Well, I'm pleased to have the opportunity to testify today before the Pepper Commission about the Robert Wood Johnson Foundation's Health Care for the Uninsured Program. These demonstration projects, it's important to understand, focus on only one aspect of the universal problem—developing more affordable products for the working uninsured.

I believe that the early lessons that we are learning from these demonstration projects will be of great value to the Pepper Commission in your deliberations about how to best insure health care for all Americans.

Given the magnitude of the uninsurance problem, it would appear to warrant a national solution of some form. Why bother learning about these efforts to expand the availability of health insurance for this small employer group? To answer this question, I think it's helpful to review the circumstances under which States and local community provider groups responded to the Robert Wood Johnson Foundation's call for proposals to demonstrate new financing and organizational arrangements for the uninsured.

In January 1986, when the Robert Wood Johnson Foundation announced its Health Care for the Uninsured Program, the Federal Government appeared to be saying that this problem would have to be resolved by State and local governments and the private sector. States were beginning to initiate State level solutions, but their funding was extremely limited.

There was, and still is to a large degree, a general belief that it would be preferable to use voluntary approaches for expanding employment-based insurance. Thus, this program, and its projects, sought to demonstrate ways to leverage public sector funds in partnership with the private sector.

Why the emphasis on the working uninsured? As you've now heard, two-thirds to three-fourths, depending on the survey data used, of the uninsured are workers or dependents of workers.

Why the emphasis on small businesses? First, employment trend data show the growth in the small business sector continues to be greater than the large employer sector. When we look at the uninsured workers and their dependents, 61 percent are employed in firms of 25 or fewer employees, and 44 percent are employed in firms with fewer than 10 employees, and this is from the very recent National Medical Expenditure Survey conducted in 1987.

The small business market is also very difficult to serve. There are reasons that Blue Cross plans and the commercial insurers have not served this market well, including the push by our own

Federal Government and large employers to act as prudent purchasers which has undermined community rating and the availability of more affordable products for small businesses and individuals.

The traditional reasons why insurers avoid or are cautious about this market include adverse risk selection, high marketing and sales costs, and high administrative costs. Based on surveys of small employers conducted by these projects, it is quite clear that cost is the primary reason for why these employers do not offer this benefit, but other factors include: they can hire without providing, their employees are covered elsewhere, they can't find an acceptable plan, they are faced with high employee turnover, their company has been turned down because it's too small, and they lack information and have difficulty in judging plans.

Given the reluctance of many small firms and their employees to purchase insurance, due primarily to high cost, and the reluctance of many insurers to sell more affordable products to this market, due primarily to fear of adverse risk selection, these demonstration projects had to devise innovative strategies to overcome these difficulties.

A variety of approaches are being used to try to make the premiums more affordable. They include: (1) cost sharing, some projects limit cost sharing to encourage beneficiaries to purchase insurance, a few others are using cost sharing to lower premiums; (2) managing the care or channeling the patients into limited provider networks; (3) using very limited benefit packages; and (4) subsidizing the premium. Some State governments are providing direct subsidies of premiums for low-wage employees, and a few projects are buying down the premium for family coverage, which is an especially difficult problem in this sector, where the employer in some instances may offer insurance, but because of the high premium cost to the employee, the employee does not elect family coverage.

A very important lesson from this demonstration is that State governments can do things to help buy down this insurance through indirect subsidies such as purchasing reinsurance, or providing stop-loss protection for plans and providers, linking these programs to high-risk pools to divert the high-cost employees, to assure that at least the group gets covered. Now, in some States, if an insurer chooses not to write for one individual, the entire group doesn't get health insurance. In addition, some of the States are financing the costs of developing and administering these plans, covering some of the marketing costs.

A number of our projects, especially those not sponsored by State governments, are negotiating discounts with providers, particularly hospitals, to lower premium costs. Some are sponsoring the creation of a State purchasing group, such as a multiple employer trust, and you'll hear more about that in a few minutes. And, some projects are providing an employer an insurance information and broker service to help small employers understand insurance and to better match insurance to the employer.

Where do these demonstrations fit into the national solutions that may be before the Pepper Commission? I think there are many ways to categorize the variety of national approaches, but they fall broadly into these four categories: (1) developing a universal, unitary form of insurance, such as used in Canada; (2) using mandates or strong tax incentives to expand employer-based coverage together with an expansion of Medicaid; or (3) mandating that all individuals have coverage, whether they have employment-based insurance or participate in a public-sponsored fail-safe system; or (4) expanding the existing public/private insurance and service mechanisms. This fourth approach would include the voluntary expansion of employer-based insurance, expanding Medicaid, expanding individual coverage through COBRA [Consolidated Omnibus Budget Reconciliation Act] and Medicaid buy-in provisions, et cetera, and expanding funds for direct service provision.

The health care for the uninsured demonstration projects fall into this fourth category. I think they'll have much to teach us about the effectiveness of this strategy.

If you believe, though, that the problems of assuring access for the 31 to 37 million Americans without health insurance warrants a more comprehensive solution, you should be interested in this demonstration for the following reasons.

First, many of the solutions designed to ensure universal access call for the Federal Government to assure a minimum basic health care or a minimum level of benefits. Well, the notion of having government assure an adequate level of health care is generally accepted by a lot of people. We haven't done a very good job in Congress or in State legislatures in defining precisely what should be that minimum level of health care, and I think our demonstration projects have been doing this, and we'll learn the receptivity of employers and employees to these limited benefit plans.

We should also learn more about the appropriate balance between cost sharing and minimum benefits, since broader benefits usually result in greater employee cost sharing unless a subsidy is available. We believe we'll learn what is the optimal balance between benefits and cost sharing.

Some solutions propose using a limited provider care network and channeling the patients into that network. We will learn about the initial employer and employee receptivity to limiting choice, and the degree to which employees will accept restrictions in the choice of providers in exchange for more affordable products.

Under some mandate approaches, and this is very important, very small firms, five or fewer employees, are exempt. Yet, research conducted by these demonstration projects shows that that's where the problem is, in terms of the number and the proportion of the small firms. And, in the table in your handout, you will see that the proportion offering health insurance is much lower for firms of five or fewer and less.

After we get six to eight employees, we begin to see penetration of 60 and 70 percent. Less than half of the firms with less than five offer this insurance.

What's especially interesting to us in the early enrollment data from these projects is that the average firm size is 3.3 employees and the average group size (employees plus dependents) is 5.3, so there is clearly a need to serve this very small market. If mandate strategies do exclude the very small firms, then we are going to have to find ways to develop more affordable products to serve them.

The extent to which these voluntary strategies work to expand private insurance coverage will inform the debate about the necessity of mandates, and we'll clarify just how much responsibility the public sector will need to assume. They should provide insight into how much of this problem can be addressed by States, and where Federal intervention and support may be necessary.

Hopefully, we will be able to give meaning to the rhetoric of a public/private partnership, and to better understand the conditions under which we can expect the private sector to really serve this market.

Any solution which relies on expanding employer-based insurance for the working uninsured must recognize that successful implementation takes time. An early important lesson, something the private insurance industry knows too well, is, it takes time to design and underwrite new products, to negotiate provider arrangements, and to market and enroll subscribers.

Then begins the critical job of monitoring enrollment and utilization data and assessing provider performance to refine product design and to modify the premium and subsidy arrangement.

Unless individuals are mandated to have insurance, marketing will be an important component of any strategy. Through these projects, we've already learned that in the absence of a direct premium subsidy, such as in the Washington Basic Health Plan, considerable time and money are needed to market and sell products to the small employer.

We have learned that strict underwriting is the norm for insurers marketing to firms with 10 or fewer employees. This demonstration should also provide valuable data for the debate on whether the insurer's fears about adverse risk selection for the small employer are justified. Early data from three of our projects shows that utilization has been lower than anticipated and lower than national averages.

To address this issue, several of these demonstrations are providing reinsurance, that means covering the cost above some amount, such as $10,000 to $20,000 per year. Others are providing a direct link to State high-risk pools for their enrollee's with preexisting conditions which might have resulted in having coverage denied.

If it turns out that employees of small firms are not really higher utilizers of health services, as our initial data demonstrate, then reinsurance and linking State high-risk pools with programs to provide more affordable coverage for small group products should resolve any remaining problems about adverse risk selection.

I would urge, though, in exchange for this protection, we should ask insurers to eliminate or greatly reduce their extensive medical underwriting and use of preexisting condition clauses for this market segment.

It's important to remember that these are demonstration projects and that their enrollment targets are modest. There are factors that contribute to high enrollment including State sponsorship, a subsidy, and products marketed to individuals.

In conclusion, this is a very difficult problem, and it requires a comprehensive solution. We can take incremental steps which build on the existing employer-based system, but we must recognize that some government intervention, in terms of regulating the insurance industry, and some financial support through direct or indirect subsidies will be necessary.

[The prepared statement of Mr. Helms follows:]

TESTIMONY PROVIDED TO

THE PEPPER COMMISSION
(The United States Bipartisan Commission on Comprehensive Health Care)

By

W. David Helms, Ph.D.
Executive Director
The Alpha Center

and

Program Director
The Robert Wood Johnson Foundation
Health Care for the Uninsured Program

July 6, 1989

I am pleased to have the opportunity to testify before the Pepper Commission today about The Robert Wood Johnson Foundation's Health Care for the Uninsured Program. These demonstration projects focus on only one major component of this complex problem--the working uninsured and their dependents. I believe the early lessons being learned from this demonstration will assist you in your deliberations about how best to ensure health care for all Americans.

Given that the magnitude of the uninsured problem would appear to warrant a national solution of some form, why bother learning about these efforts to expand the availability of health insurance for this group? To answer this question, it is helpful to review the following circumstances under which states and local community/provider groups responded to The Robert Wood Johnson Foundation's call for proposals to demonstrate new financing and organizational arrangements for the uninsured:

1. In January of 1986, when the Robert Wood Johnson Foundation announced its Health Care for the Uninsured Program, the Federal Government appeared to be saying that this problem would have to be resolved by state and local governments and the private sector. States were beginning to initiate state-level solutions, but their funding was extremely limited. There was (and still is, to a large degree) a general belief that it would be preferable to use voluntary approaches for expanding employment-based insurance. Thus, the Health Care for the Uninsured Program projects sought to demonstrate ways to leverage limited public funds in partnership with the private sector.

2. Why the emphasis on the working uninsured? As I am sure you are now aware, a large proportion (68.2% in 1986) of the uninsured are workers or dependents of these workers.

3. Why the emphasis on small business? Employment trend data show that the growth in the small business sector continues to be greater than in the larger employer segment. When we look at uninsured workers and their dependents, 61% are employed in firms of 25 or fewer employees and 44% are employed in firms with fewer than 10 employees. (Source: Findings from National Medical Expenditure Survey No. 1, "Uninsured Americans: a 1987 Profile," (forthcoming), by Pamela Farley Short, Alan Monheit and Karen Beauregard. NCHSR/HCTA, Rockville, MD.)

- The small business market is very difficult to serve. There are reasons Blue Cross Plans and the commercial insurers have not served this market well including:

  o The push to have the Federal Government and large employers act as prudent purchasers has undermined community rating and the availability of affordable products for small businesses and individuals.

  o The traditional reasons why insurers avoid or are cautious about this small employer market include: adverse risk, high marketing and sales costs, and high administrative costs.

Based on surveys of small employers conducted by these projects, it is quite clear that cost is the primary reason given for why these employers do not offer this benefit. The reasons small employers don't offer health insurance include:

o cost (too expensive)
o can hire without providing
o employees covered elsewhere -- spouse or individual policies
o can't find an acceptable plan
o high employee turnover
o company turned down because too small
o lack of information/difficulty in judging plans

Given the reluctance of many small firms and their employees to purchase insurance (due primarily to high cost) and the reluctance of many insurers to sell more affordable insurance products to this market (due primarily to fear of adverse risk selection) these demonstration projects had to devise innovative strategies that would overcome these difficulties.

The approach being used is to develop new plans or to modify existing products specifically for uninsured small businesses. The strategies being pursued to make insurance premiums affordable, both to the firm and to the employees, include: [See Tables 1 and 2, "Approaches Being Developed"]

o Cost sharing: Some projects limit cost-sharing to encourage beneficiaries to purchase insurance; a few have significant cost sharing provisions to lower the premiums.

- Managed care/limited provider networks: All projects use managed care arrangements such as health maintenance organizations, preferred provider organizations or physician gatekeepers to monitor services provided; some projects also use very limited provider networks to channel patients to lower-cost providers (e.g., public hospitals and community health centers).

- Basic benefits: A few projects emphasize basic ambulatory care and inpatient hospital services with limited catastrophic coverage.

- Premium subsidies: Some state governments are providing direct subsidies of premiums for low-wage employees and a few projects are "buying down" the employee share of family coverage.

- Indirect subsidies and administrative support: Some state governments are purchasing reinsurance or providing stop loss protection to limit provider exposure while others have established links with their high-risk pools; in addition, many states are helping to finance the development, marketing, and other administrative expenses of offering insurance to small employers.

- Provider discounts: A number of projects, especially those not sponsored by state governments. are negotiating discounts with providers, particularly hospitals, to lower premium costs.

- Creation of state sponsored purchasing group: e.g., multiple-employer trusts.

- Use of state high risk pools: Some states are using their high risk pools to divert higher cost cases and thereby keep small group rates more affordable. This approach is also used to reduce use of medical underwriting and limit imposition of pre-existing condition clauses.

- Provide an insurance information and broker service. Some of the projects are providing this information as an adjunct to their demonstration; one of the projects, the United Way of the Bay Area, is demonstrating whether an information and referral service using existing products will increase the coverage in the small business market.

Where do these innovations fit into the national solutions under consideration? While there are many ways to categorize these proposals, there are basically four policy strategies to address the large number of uninsured:

1. Develop a universal, unitary system of health insurance.

2. Use mandates or strong tax incentives to expand employment-based coverage. This approach is generally combined with an expansion of Medicaid.

3. Mandate that all individuals have coverage, either through employment-based insurance or through a publicly sponsored "fail-safe" system.

4. Expand and refine existing public-private insurance and service mechanisms:

   o Voluntary expansion of employment-based insurance (e.g. these demonstration projects)

   o Expand Medicaid

   o Expand individual coverage
     - COBRA continuation of benefits
     - Medicaid buy-in
     - State high risk pools
     - State subsidies, such as with Washington's Basic Health Plan

   o Expand funds for direct service provision
     - Subsidize disproportionate uncompensated care providers
     - Fund designated providers for the uninsured such as public hospitals, community health centers, and medically-needy clinics

The Health Care for the Uninsured Program demonstration projects fall into the fourth category and will have much to teach us about the effectiveness of this strategy. If you believe the problems of assuring access for the 31-37 million Americans without insurance (the new CPS estimate for 1987) warrant a more comprehensive solution, you should also be interested in the results of this demonstration because:

1. Many of the solutions designed to assure universal access call for the Federal Government to assure the provision of "basic health care" or a "minimum level of benefits". While the notion of having Government assure that "basic health care" is available to all is generally accepted, we do not have agreement on what constitutes this minimum level.

   - Some of these projects have defined a more limited benefit plan based on their surveys of what benefits small employers and their employees want and on their analysis of the types of products that they were actually able to sell. We will learn about employer and employee receptivity to various limited benefit plans.

   - We should also learn about appropriate balance between cost sharing and minimum benefits. Since broader benefits usually result in greater employee cost sharing unless a subsidy is available, what is the optimal balance between benefits and cost sharing?

2. Some solutions propose using a limited choice provider network -- paying most of the cost of care only when beneficiaries use certain designated providers who have met a set of criteria for efficiency -- and aggressively managing the care provided.

   - We will learn about the initial employer and employee receptivity to limiting choice and the degree to which employees will accept restrictions in exchange for more affordable premiums.

3. Under some mandate approaches, very small firms -- five or fewer employees -- are usually exempt. Yet research conducted by these demonstration projects shows that this is where the problem is in terms of the number and proportion of very small firms not offering insurance.

   - The proportion offering health insurance is much lower for firms with five and fewer employees. (See Table 3).

   - The average size of the the firms enrolling in these demonstration projects ranges from 2.1 to 5.0. (See Table 4).

   - If mandate strategies do exclude the very small firms, the development of affordable products for this group will continue to be a high priority.

4. The extent to which these voluntary strategies to broaden private insurance coverage work will inform the debate about the necessity of mandates and will clarify just how much responsibility the public sector will need to assume. They should provide insight into how much of this problem can be addressed by states and where federal intervention and support may be necessary. Hopefully, we will be able to give meaning to the rhetoric of a public-private partnership and to better understand the conditions under which we can expect the private sector to serve this market.

5. Any solution which relies on expanding employer-based insurance for the working uninsured must recognize that successful implementation takes time. An important early lesson we have already learned -- something the private insurance industry knows only too well -- is that it takes time to design and underwrite new products, to negotiate provider arrangements, and to market and enroll subscribers. Then begins the crucial job of monitoring enrollment and utilization data and assessing provider performance to refine the product design and to modify the premium and/or subsidy arrangement.

6. Unless individuals are mandated to have insurance, marketing will be an important component of any strategy. Through these projects, we have already learned that in the absence of a direct premium subsidy (like the Washington Basic Health Plan), considerable time and money are needed to market and sell the products -- perhaps more than we realized before the demonstration began.

7. We have learned that strict underwriting is the norm for insurers marketing to small firms with 10 or fewer employees. This demonstration should also provide valuable data for the debate on whether the insurers' fears about adverse risk selection for the small employer are justified. Early data from our Arizona project shows that the early utilization for an HMO product in Tucson is even lower than national averages. (See Table 5). To address this issue, several of these demonstration projects are providing reinsurance (usually for costs per insured that exceed $10,000 - $20,000 per year). Others are providing a direct link to their state high risk pool for those enrollees with pre-existing conditions which might have resulted in either that person or even the entire group being denied coverage. If it turns out that employees of small firms are not really higher utilizers of health services, then reinsurance and linking state high risk pools with programs to provide affordable small-group products should resolve any remaining questions about adverse risk selection. In exchange for this protection,

we should ask insurers to eliminate or greatly reduce their extensive medical underwriting and limitations on pre-existing conditions for this market segment.

8. It is important to remember that these are demonstration projects and that there enrollment targets are modest. From our early experience, it appears that the following factors contribute to higher enrollment:

   o State sponsorship -- products dependent on provider discounts may not be considered as stable.

   o For lower income employees, a subsidy helps.

   o From Washington's Basic Health Plan, it appears that subsidized products marketed directly to individuals achieve high enrollment quickly.

In conclusion, this is a difficult problem and it requires a comprehensive solution. We can take incremental steps which build on the existing employer-based system but we must recognize that some government intervention (in regulating the insurance industry) and financial support (through direct and indirect subsidies) will be necessary. By virtue of being operational, these projects are demonstrating steps that can provide some relief in the interim. We would be pleased to continue to keep the Commission and its staff appraised of the evolving results of this demonstration.

TABLE 1

RWJ HEALTH CARE FOR THE UNINSURED PROGRAM
Approaches Being Developed (1)

Project		Develop - Modify - Use Insurance				
		Small Firm	Individual/ Self-Employ.	Limited Benefits Option	Major Cost Sharing	Limited Provider Network
1.	University of Alabama at Birmingham Hospital	●		●		●
2.	Arizona (AHCCCS)	●	●	●		●
3.	San Diego Council of Community Clinics	●		●		●
4.	City/County of Denver	●			●	●
5.	Florida	●				
6.	Maine	●	●			
7.	South Cove CHC, Boston	●		●		
8.	Michigan League of Human Services/State Medicaid Program	●				
9.	New Jersey	●				
10.	Tennessee Association of Primary Health Care	●				●
11.	Intermountain Health Care Salt Lake City	●			●	●
12.	HealthSystems Resources/Basic Health Plan, Washington State		●			
13.	West Virginia	●	●			
14.	Wisconsin	●				
15.	United Way of San Francisco	Referral Service		●	●	

TABLE 2

RWJ HEALTH CARE FOR THE UNINSURED PROGRAM
Approaches Being Developed (2)

	Subsidy			Tie to Other State Programs			
Project	Direct Premium	Indirect: Pooling; Admin.	Discounts From Providers	Medi-caid	Public Empl. Insur.	High Risk Pool	Uncomp. Care Pool
1. University of Alabama at Birmingham Hospital			●				
2. Arizona (AHCCCS)		●	●	●			
3. San Diego Council of Community Clinics			●				
4. City/County of Denver			●				
5. Florida	●	●	●				
6. Maine	●		●	●		●	
7. South Cove CHC, Boston		●	●				
8. Michigan League of Human Services/State Medicaid Program	●			●			
9. New Jersey	●						●
10. Tennessee Association of Primary Health Care			●				
11. Intermountain Health Care Salt Lake City			●	●			
12. HealthSystems Resources/Basic Health Plan, Washington State	●						
13. West Virginia	●	●			●		
14. Wisconsin	●					●	
15. United Way of San Francisco		●					

TABLE 3.

HEALTH CARE FOR THE UNINSURED PROGRAM
EMPLOYER SURVEY DATA

Proportion of Small Employers, By Size, Offering Health Insurance

DENVER			WISCONSIN		
SIZE OF FIRM	NUMBER OF FIRMS	PERCENT	SIZE OF FIRM	NUMBER OF FIRMS	PERCENT
0-1	130	25.6	0	577	30.2
2-5	404	57.4	1-4	2108	39.0
6-10	139	74.8	5-9	1051	61.9
11-15	45	82.2	{ 10-19	667	78.7
16-20	54	92.6			
			20-49	456	86.8
			50-99	126	97.6

TABLE 4

RWJ HEALTH CARE FOR THE UNINSURED PROGRAM
Enrollment Data and Group Size

Project	Enrollment Date	Current Enrollment As of 7/1/89	Average Firm Size (# employees)	Average Group Size (# lives)
Arizona (AHCCCS)	7/1/88	820 lives	3.0	4.0
Florida	7/1/89	197 lives 40 firms	2.8	4.8
Maine	6/1/88	441 lives 124 firms	2.1	3.6
Mich. League of Human Services/Medicaid Prog.	5/1/88	800 employees 114 firms	5.0	7.0
Tennessee Association of Primary Health Care	7/1/89	329 lives	2.3	4.0

TABLE 5
HEALTH CARE GROUP

UTILIZATION DATA

Outpatient	HCG	HCFA	GHAA
Encounters per member annualized:	4.4	4.7	4.1
Total emergency room visits:	105		
Prescriptions per member annualized:	3.8		
Hospital			
In-patient days per 1000 annualized:	180	325	413
Average length of stay (days):	4.1	4.4	4.7
Obstetrics			
Deliveries (total):	3		
In-patient days (total):	4		
Average length of stay (days):	1.3		

Major business category: Services

Average group size: 4 Nearly 55% of coverage is for one party.

Membership: Under age 39: 74%; 39 - 55: 21%; over age 55: 5%

Sex ratio: 52% Female, 48% Male

Approximately 69% of the employees are covered by Option 2 [Hospital, Surgical, Physician, X-ray and Laboratory charges up to $250,000; Physician or Specialist referral office visit: $5.00 co-pay; Emergency room: $25.00 co-pay; Authorized x-ray, lab, ambulance: No charge; Pharmacy: $3.00 co-pay]. Option 1: 22%; Option 3: 3%; Option 4: 6%.

HCG: Health Care Group utilization statistics for May 1, 1988 through April 30, 1989. Average monthly enrollment: 445.2. Total member months: 5,342.

HCFA: HCFA statistics exclude Medicaid and represent health plans with less than 10,000 members and are Type 19 federally-qualified HMOs.

GHAA: GHAA statistics represent health plans aged 3 years or less with enrollees under age 65.

GGG/6/27/89

Chairman OAKAR. Thank you very much, Mr. Helms.

Mr. Galles?

STATEMENT OF JOHN PAUL GALLES, EXECUTIVE VICE PRESIDENT, NATIONAL SMALL BUSINESS UNITED

Mr. GALLES. My name is John Galles. I'm executive vice president of National Small Business United, which has over 50,000 small businesses as members, and a number of small business organizations, including the Cleveland Organization of Smaller Enterprises [COSE], which is one of our more active organizational members, and happens to have a program which we hope will be a model for other programs around the country.

But, let me tell you that outside of Cleveland our membership continues to have a considerable concern about the availability and the affordability of health care coverage in this country.

I really want to take an opportunity to thank the Bipartisan Commission on Health Care for holding these hearings, and for being so open in its search for solutions to the major health care problems facing this country, that is, problems including the uninsured as well as long-term care.

It's our desire to productively address the problems before us so that we can find solutions. While we have problems with some of the solutions that have been proposed, we expect to contribute to this discussion in a constructive manner and hope that there is an attentive audience to the problems of small business.

You've heard a great deal of statistics and some examples of demonstration projects that have helped us learn about the nature of the problem for small business. I guess I'd like to emphasize a number of those.

The problems are manifold. They are complex, and, in fact, small business is trapped by health care regulations. We are trapped by Federal regulations, including the recently passed section 89, which is under a reform at this point. We are trapped by State regulations, which impose coverages on small businesses and their employees. We are trapped by insurance companies, who make independent decisions about who gets covered. We are trapped by insurance underwriting, which happens to make sure that each individual subscriber is rated in a way that tries to in some way match premiums with costs. And, when you are very small that creates many problems. We are also trapped by the very size of small business, and you've heard a little bit about that to this juncture, but small business is trying its best to comply and to provide its employees with coverage in a very tough situation.

We have seen a huge growth in the number of small businesses providing health care coverage since 1980. I think that has come primarily as a result of our climb out of the recession of the early 1980's and the long recovery period we've had since then. Small businesses provided nearly two-thirds of all the new jobs since 1980, and they want to keep those employees. They want to keep the qualified, the talented employees that they've hired, and one way to do that, one way to compete for those employees with large businesses is to make sure that they provide that coverage in a consistent manner and in a quality manner.

Small businesses, in our membership, have gone from 77 percent of our members providing health care coverage to 91 percent between 1987 and 1988. I think that's largely because we have fewer people in the work force, and largely because small businesses are becoming more competitive for the workers in the marketplace.

We still realize the desperate straits of many in need of health care and that proper health care should be basic to the people of an advanced and civilized country. We hasten to add, though, that this is not a problem which can simply be dumped at the door of small businesses around this country who simply cannot afford it. The cost of an average worker's family policy averaged nearly $3,000 in 1988, and the cost will continue to rise.

Let me play out for you some of the reasons why small business costs are extraordinarily high. One has to be that they are subject to many of the State mandates that are in place, the mandates that require coverage for mental health, for drug and alcohol abuse, for many of the concerns that we all have as a Nation but simply can't be added into everybody's premium without some cost to the overall population at large.

There are problems for small businesses because of their size. That impact is primarily a 20- to 30-percent increase over other premiums that might be charged to other businesses. They are charged for preexisting conditions. Those conditions are ones that underwriters look at from insurance companies that range from things like cancer and heart ailments, to blood pressure and weight, to allergies, things that all of us may find fairly commonplace, but, nevertheless, items that some insurance companies simply will refuse to cover. That may result in rejecting that small business for health care coverage or appropriately raising that premium for the risk that's involved.

Small businesses also are affected by the claims that that small business experiences. One St. Louis firm recently wrote to me and talked about 100-percent increase in their premiums, merely because of a claim of one of their employees. Now, that is an overwhelming increase, one that's very hard to absorb in normal inflationary increases in prices.

There are examples of insurance companies who skim small businesses or workers from one policy to another. They only want the healthy businesses, the healthy employees, paying into their insurance company. That's a real concern because that leaves many small businesses trapped with other programs, group programs that may be escalating in cost because they can't retain the healthy employees in their mix.

There is cost shifting that goes on, and it's not just the cost shifting that results from the fact that our Federal Government can't afford the costs of Medicare and Medicaid, it's also a cost shifting from large business to small business. When large businesses in a community can go to a hospital and negotiate for lower rates for services rendered, the actual costs for those services are passed on to those small businesses and those private insurance companies that cover those employees who cannot negotiate for the same basic reduction in rates.

And, in fact, you could take that a step further and suggest that by the very nature of our health care system, small businesses are substantially disenfranchised from having any impact on our health care system.

There is the cost of technology, there is the cost of a small business employing older people, younger people, part-time workers. All of those have a substantial impact on the cost of health insurance to small business.

We have a hope that this Commission will suggest that small business be given some freedom from the burdensome regulation, that we can encourage more group purchasing by small businesses by businesses of different types and sizes, so they can confront the health care providers in their communities and, hopefully, maintain some control over those costs.

Thank you very much.

[The prepared statement of Mr. Galles follows:]

NSBU
NATIONAL SMALL BUSINESS UNITED
"Serving America's small businesses since 1937"

Statement

of John Paul Galles
Executive Vice President,
National Small Business United

before the
Bipartisan Commission
on Comprehensive Health Care

July 6, 1989

My name is John Paul Galles, and I am the Executive Vice President of National Small Business United, an association very much concerned about the costs of health care and involved in the search for more available and affordable health care coverage. I would first like to take this opportunity to thank the Bipartisan Commission on Health Care for holding these hearings and for being so open in its search for solutions to the major health care problems facing this country. It is our hope that the Commission will provide a path toward meaningful and helpful changes that we can all support.

As you may well know, National Small Business United (NSBU) is the oldest association exclusively serving the small business community of our nation--for over 50 years now. NSBU serves over 50,000 individual companies with members in each of the 50 states, as well as local, state, and regional organizations. NSBU is uniquely qualified to express the views of the small business person. It is our desire to productively address the problems before us in order to help produce a solution with which we all may be able to live.

The problems facing this country and its small businesses in the area of health care are manifold and complex. They include the interlinking spiral of health care and insurance costs, the significant number of uninsured people in this country, the inability of small businesses to solve the problem alone, and the conflict of finding a solution to one aspect of the problem without worsening another.

There are no easy answers to these questions and problems. The Employee Benefit Research Institute has reported that 35 million Americans, about 14.5 percent of the population, are uninsured. This lack of insurance is especially prevalent in the small business sector, mainly because insurance is so expensive, and small businesses are the least able to incur such an expense. And many say that insurance is so expensive largely because so many small businesses do not have it--leaving the rest of the market to pick up the bill. This is a clearly vicious circle that must end.

As we can plainly see, health issues are complexly woven with one another, and everything affects everything else--making solutions much more complex. Still, NSBU realizes the desperate straits of many in need of health care, and that proper health care should be basic to the people of an advanced and civilized country such as ours. We hasten to add, though, that this is not a problem which can be solved simply by placing more burdens upon the backs of those in our economy who simply cannot afford it.

PROBLEMS WITH THE OBVIOUS SOLUTION: MANDATES

In a recent NSBU survey, 82% of respondents said that a federally mandated health insurance plan would be detrimental to them as employers. Still, many consider the most obvious solution to the crisis of the uninsured is to require all employers to insure their employees. The cost of an average worker's family policy averaged $2,986 in 1988, and the costs continue to rise. The same firms that employ most (60%) of the uninsured workers--the ones with fewer than 25 employees--are the ones that most operate on the margin, have the greatest rate of turnover, and are most likely to go out of business. There is a reason why they do not provide health insurance--quite apart from the usual image of being greedy and uncaring: they simply do not have the means.

At the bottom end of the pay scale, there is no flexibility in wages; a mandated approach would allow no flexibility in benefits. The only flexibility allowable would be the flexibility of whether to fund the job itself. Choice between a job or adequate health care is no choice at all, either for the employer or the employed. It should not be a choice for Congress either.

I know you have heard over and over again how so many of our small businesses often do not have the means to carry insurance. You hear it because it is the truth. Mandating employers to do more of what they already cannot afford is no solution at all.

There are many specific arguments to be made against specific mandated approaches. I shall not go into those because any mandated plan will be completely inadequate and unacceptable because it fails to address the essential problem of health care in the U.S.: its cost.

HEALTH CARE COSTS

There are many contributing factors which make health care and its insurance expensive for all concerned; there are still other factors which cause these costs to be higher still for small employers. I shall attempt to address both the larger, more basic cost problems which infect our entire health care delivery system and the particular problems within the current system which are so ruinous for small businesses.

The most essential cause of the high cost of health insurance is the high cost of health care. There are, however, many reasons for the high cost of health care. Within the current system, there is little incentive to search out more affordable ways to the same level of health; high technology makes many procedures more palatable for most, increasing their demand (and price); health care providers' liability insurance premiums substantially drive up their costs; and the cost-shifting problem feeds upon itself, causing high cost to lead to higher cost in a never-ending upward spiral.

The cost-shifting problem is a result of the uninsured and cutbacks in Medicare. In the first Reagan Administration, a plan was enacted that allowed Medicare to set limits on the amounts it is willing to pay to doctors and hospitals for specific sorts of medical care. The measure was designed to combat the rising cost of medical care; the thought was that Medicare was being overcharged because it was willing to pay. Medicare's prospective payment system was instituted to deliver a fair, not bloated, recompense to doctors and hospitals. Beyond the frequent charge that these regulations have reduced the quality of care received by our elderly, there is also evidence that this plan is actually driving up health insurance prices--some say by as much as 20%--for all other consumers. The most stark realization, though, may be that, even with this new plan in place, Medicare continues to grow. By the year 2000, it will have surpassed Social Security as the most costly federal program.

Many suggest that Medicare is paying, not too much for things, but for too many things. A great debate rages about whether it is the role of the Medicare system to provide possible care so much as clearly necessary care. The most viable way of bringing down the pricetag of Medicare may be to more severely limit the sort of medical care that it will cover.

Aside from the cost-shifting and medical liability problems, health care costs will continue to rise because the public will continue to receive more and more new treatment as that treatment becomes more and more convenient and effective and continues to be paid for by someone else. The fact is that, for the insured, there is almost no consumer sensitivity at the point of demand. Essentially, as we move into the Twenty-First century, aggregate health care is becoming more expensive because there is becoming more of it. For so long as insurance continues to pay for new procedures--ever increasing in numbers--its price will continue to rise, and fewer Americans will be able to afford it.

In order to cope with this problem, insurers are requiring advance approval for surgery, Medicare has adopted a new method of restricting unnecessary stays, and employees are beginning to pay a higher percentage of their health care bill. Nevertheless, health care has risen from 10.4% to 11.1% of GNP since 1985; in 1965, it was 5.9%. The ultimate solution may involve rationing health care. Many types of care--presumably the least necessary--may be denied. Otherwise, the high-tech medicine that has been such a boon to so many sick may become an economic bust of superfluous care.

SMALL BUSINESS ACCESS TO HEALTH CARE

Small businesses tend to provide a lower level of health insurance to their employees than larger businesses. The simple reasons for this disparity are high health care costs and low profitability. There is little the Commission can do about the latter problem, so I will concentrate upon the former.

Insurance premiums are higher for smaller companies than for their larger counterparts because they have fewer employees over which to spread the risk. The workforce employed by these small firms is, in itself, a problem. Small businesses employ a disproportionate number of old workers, part-time workers, and women--all of whom tend to have higher-than-average insurance premiums. Further, the employees of the smallest firms must endure an individual underwriting process. Each employee's health record is investigated in order to determine, individually, the appropriate level for premiums. The cost of running these analyses is also then passed on to the consumer in the cost of higher premiums. Such individual underwriting is not necessary for larger businesses with significant numbers of employees.

To illustrate the gravity of the problem, an analysis by the Health Insurance Association of America has estimated that employers with fewer than 100 employees pay 20 to 30 percent higher premiums than employers with more than 100 employees. Hence, the problem is not simply that all insurance is so expensive that only large, wealthy corporations can afford it; the problem is that small, marginal companies actually get a substantial price hike.

The major reasons for this disparity, says the insurance industry, are acquisition costs, administrative costs, and the low renewal rate among small firms. Insurers' marketing costs are higher per business (because there are so many small businesses to which to market, and so few who actually buy from any particular company) and must be repeated more often because of a low rate of renewal. There are also many other overhead, administrative, costs which are higher for smaller firms, such as tracking of employees, maintenance of accounts, billing, and collection. The insurers claim that the major way to reduce these costs is to increase the size of the risk pool.

Smaller employers are lacking in other resources that are at the disposal of larger employers. Probably the foremost among them is the ability of large employers to negotiate with health care providers to receive special deals and rate reductions. These large corporations have the ability, for instance, to self-insure (a move which further reduces their costs in and of itself) and approach a health care provider and agree to pay all bills within 30 days in exchange for a 20% reduction in the total bill. Small employers do not have the market power to negotiate this sort of a special arrangement.

Given this set of circumstances, it is indeed ironic that it has largely been bigger businesses that have complained about the impact of cost shifting on their bottom lines. These big businesses have suggested that, if more small businesses insured more of their employees, health insurance costs would not be shifted to big businesses. It is ironic because the only employers who are paying the full cost of their health care, who are not receiving special deals, who are hardest hit by cost shifting are small employers. Perhaps if larger businesses paid the real cost of their health care bills, cost to small employers could be reduced to the point where many more of them could afford to provide health care for their employees.

SOLUTIONS

All of these circumstances lead us to the conclusion that the most essential problem of small business is lack of market power, which is a function of size. Generally, ERISA laws do not allow heterogeneous businesses to group together to purchase insurance or to self-insure and deal with health care providers. Those rules must change. To solve their unique problems, the small employers in a building, on a block, of a city or a state should be allowed to consort to buy insurance. The greatly expanded creation of Multi-Employer Trusts (METs) would be a major step forward in giving small employers the necessary flexibility to be a discriminating consumer. These METs are designed to achieve the goal of reducing cost through centralized administration and a more stable rating. One of the primary problems with establishing METs is that they currently must conform to all state regulations, thereby increasing their costs and causing them to miss their targeted customers.

Deductibility of premiums remains a major problem. Unincorporated entities are allowed to deduct only 25% of the full cost of their premiums. This discriminatory tax treatment has had several negative results. Primary among these is the fact that, among firms with fewer than 10 employees, corporations are more than twice as likely to provide health benefits than a sole proprietorship. In fact, a 1983 study by the Employee Benefits Research Council indicated there were are more than nine million self-employed individuals without insurance--one in four of all the uninsured. Clearly, this discriminatory practice on the part of the government has a severe impact on extending the numbers of the uninsured. Beyond simply extending the 25% deductibility of health care costs for sole proprietorships, the deductibility should be raised to the full 100% enjoyed by large corporations.

Benefits mandated by the individual states also discourage the extension of benefits. The 50 states all have laws requiring that specific health benefits be included in all employee insurance packages offered--often dramatically increasing the cost of coverage from what it would have been without that coverage. Further, these mandates drive up costs by requiring a term of coverage for former employees, increasing not only real cost, but also the aggregate administrative cost. If employers cannot attain this level or sort of coverage, it is illegal for them to provide any coverage at all. This sort of mandate prevents small employers from starting a plan in the first place, and it works strongly toward the cancellation of any plans that may be in effect. A 1988 study by the National Center for Policy Analysis has suggested that the number of people who are prevented from receiving coverage as a direct result of state mandates could be as high as 9.3 million.

ERISA was designed to supercede state mandates. However, in 1985 the Supreme Court ruled that the McCarran-Ferguson Act of 1945 still allowed states to regulate insured benefit plans. The court did, however, agree that ERISA protects self-insured plans. Hence, for the large employers who can afford it, the trend toward self-insurance. Only small employers, already with the least means and the highest insurance premiums, are left to face the high costs of state mandates. Also, private insurance companies continue to charge ever-increasing rates as their risk-pools disappear into the self-insured market.

NSBU also supports the establishment of risk-pools to insure those individuals who are otherwise uninsurable. Subsidized risk pools may also be a viable option for insuring low income individuals. We oppose, however, the establishment of risk-pools which are funded exclusively by employer assessments via taxes on insurance carriers. Even if the cost were spread across all businesses, the cost to small business of insuring otherwise uninsurable individuals would be enormous, but current laws would exempt self-insured plans from such an assessment, leaving half the insurance plans--predominately small business--to foot the entire bill. The best way to finance such risk pooling is through the broadest possible tax base. A system financed by general funds (and, at some level, by the employer of the individual) and aimed at the uninsurable could well be an acceptable alternative and a big step forward in the health care debate. After all, these uninsurable individuals represent a societal problem, not a small business one.

Again, I appreciate the opportunity to present our views to you here today. NSBU is eager to be of any future assistance you may find necessary. I have already had excellent discussions with the outstanding staff you have assembled. I look forward to continuing to develop a strong working relationship with the Commission in our mutual endeavor to extend appropriate health benefits to all in need.

Chairman **Oakar**. Thank you very much.

I'm going to go on to the next panel and then come back.

We're delighted to have our own small business organization in greater Cleveland represented here today, because I think from what I know about it, they have attempted to address all the concerns that you've had. They will acknowledge it's not a perfect plan, but it is a tremendous plan that services about 7,000 to 8,000 people in our city, so we are delighted to have John Polk, who is the director of COSE, and Brad Roller, who is the president of COSE, which is our small business organization. Brad is the president of a very fine small business himself, which he is free to identify and give a plug for if he likes, and, John, we'll start with you. You can tell this Commission the experience of greater Cleveland and surrounding area small businesses and how they addressed the need for insurance for your employees.

STATEMENT OF JOHN J. POLK, EXECUTIVE DIRECTOR, COUNCIL OF SMALLER ENTERPRISES [COSE]

Mr. **Polk**. Thanks, Congresswoman Oakar.

We are going to try to keep our prepared comments brief, because we are anxious to get to your questions.

My name is John Polk, and I'm a vice president of a staff of the Greater Cleveland Growth Association, which is Cleveland's Chamber of Commerce, and I serve as executive director of the association's Council of Smaller Enterprises, affectionately referred to as COSE.

COSE's job is to provide information and services to the small companies which are members of our association. The 9,400 small companies which are members of COSE look to us for programs and management education, technical assistance, government advocacy, and for participation in the Nation's large proprietary group health plan for small employers.

Nearly 7,600 of our member companies participate in at least one of the group health care plans we sponsor for local employers. Those companies provide access to affordable health care coverage to more than 56,000 workers, and a total of 130,000 people here in greater Cleveland.

Our member companies will invest more than $140 million in group health care premiums with our sponsor carriers this year.

The companies participating in our plans are generally very small. The average size is a group with seven employees, and nearly 60 percent of our groups have fewer than five workers.

So, we think that our organization understands the realities of this marketplace pretty well.

Companies are joining our plans in record numbers because they work. In the last 5 years, the average cost of health insurance provided by commercial carriers to small groups in our area has increased a cumulative 106 percent. The cost has more than doubled.

In the same period, COSE's plan costs have increased a combined 21.4 percent. All this, while the number and quality of plans have increased for our members' use.

Our success is the result of hard work, tough management, and tough decisions, and our continuing success is based on four major factors.

First, of course, is our size, which is both the result of our successful efforts on our members' behalf, and partially its cause. Right now, about 1 person out of 10 in Cuyahoga County is part of our plans. That gives us significant purchasing power in our local area, and that bargaining power gives us the ability to negotiate aggressively for our member companies.

The second factor is our active and aggressive management. We work hard, both to keep our plans operating in our members' best interest collectively, as well as to strike the appropriate balance between advocacy for our members and tight and professional program management.

In the general health care marketplace, there is no advocate for the interests of small employers. We have an excellent professional staff and a core of knowledgeable volunteer leaders who guide our plans, directed not by a desire to make money, but by a desire to provide our members with excellent service and to provide our carriers with a fair deal, not as fair as our carriers might like, but the fairest deal we can get.

The third reason is our long-term orientation. COSE doesn't try to be the best deal for everybody every time. Our goal is to be the best deal for the largest number of people over the long haul. In the past several weeks, we've heard that another major Ohio health insurer has targeted our group for a little raiding, and we understand how that works. A company selects and identifies groups within our membership, either by size of company or by industry category, and presents to that targeted group of companies a special deal. Whatever you are paying in health insurance premium now we will reduce by 15 percent. That produces a very good deal for Joe COSE member in the short term, but in a year from now, when those rates go up 40 percent, generally speaking those companies return to our plan.

We don't want to do that in our organization because it's not honest and it's not fair. We want to know that our plan will be a good deal for our members, not just tomorrow, but 5 years from now.

The fourth reason for our success, and the most important one, is that we have an excellent relationship with an innovative and creative insurance carrier. All our management expertise and all our small business advocacy would be fruitless if we didn't have a primary carrier who wanted to do business with us, and who recognized that a good deal with us was in their best interest as well.

Blue Cross/Blue Shield of Ohio, and its CEO [chief executive officer], John Berry, has treated us like a major customer and has helped us to solve our problems and has worked with us to capitalize on opportunities in our local marketplace. We enjoy a unique and important relationship with this carrier, one which has been mutually beneficial and mutually profitable, and their commitment to COSE is what makes our plan uniquely successful.

We believe that our experience can be valuable to other companies seeking to address the health care crisis through the formation of innovative private sector partnerships. Our success demonstrates that such an approach is possible. It also demonstrates the power of a creative problem-solving and market-oriented effort to addressing these many concerns. It is far from perfect, as I'm sure that our further discussion will demonstrate, but we do believe that our program is the best that Cleveland's small business community has got.

[The prepared statement of Mr. Polk follows:]

COSE
COUNCIL OF SMALLER ENTERPRISES
A DIVISION OF THE GREATER CLEVELAND GROWTH ASSOCIATION

STATEMENT BY
JOHN J. POLK
EXECUTIVE DIRECTOR
COUNCIL OF SMALLER ENTERPRISES

BEFORE THE
BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE
CLEVELAND, OHIO
JULY 6, 1989

Cleveland
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MADAME CHAIRMAN, MY NAME IS JOHN POLK. I'M A STAFF VICE PRESIDENT OF THE GREATER CLEVELAND GROWTH ASSOCIATION, CLEVELAND'S CHAMBER OF COMMERCE, AND SERVE AS EXECUTIVE DIRECTOR OF THE ASSOCIATION'S COUNCIL OF SMALLER ENTERPRISES (AFFECTIONATELY REFERRED TO AS COSE).

COSE'S JOB IS TO PROVIDE INFORMATION AND SERVICES TO THE SMALL COMPANIES WHICH ARE MEMBERS OF OUR ASSOCIATION. THE 8,300 SMALL COMPANIES WHICH ARE MEMBERS OF COSE LOOK TO US FOR PROGRAMS IN MANAGEMENT EDUCATION, TECHNICAL ASSISTANCE, GOVERNMENT ADVOCACY, AND PARTICIPATION IN ONE OF THE NATION'S LARGEST PROPRIETARY GROUP HEALTH PLANS FOR SMALL EMPLOYERS.

NEARLY 6,200 OF OUR MEMBER COMPANIES PARTICIPATE IN AT LEAST ONE OF THE GROUP HEALTH CARE PLANS WE OFFER TO LOCAL EMPLOYERS. THOSE COMPANIES PROVIDE ACCESS TO AFFORDABLE HEALTH CARE COVERAGE TO MORE THAN 44,000 WORKERS, AND A TOTAL OF ABOUT 120,000 PEOPLE. OUR MEMBER COMPANIES WILL INVEST MORE THAN $100 MILLION IN HEALTH CARE PREMIUMS WITH OUR SPONSORED CARRIERS THIS YEAR.

THE COMPANIES PARTICIPATING IN OUR PLANS ARE GENERALLY VERY SMALL; THE AVERAGE SIZE IS A GROUP WITH SEVEN EMPLOYEES, AND NEARLY 60% OF OUR GROUPS HAVE FEWER THAN FIVE EMPLOYEES.

COMPANIES ARE JOINING OUR PLANS IN RECORD NUMBERS BECAUSE THEY WORK. IN THE PAST FIVE YEARS, THE AVERAGE COST OF HEALTH INSURANCE PROVIDED TO SMALL GROUPS BY INSURANCE COMPANIES IN OUR AREA HAS INCREASED A CUMULATIVE 106 PERCENT; IN THE SAME PERIOD, COSE'S PLAN COSTS HAVE INCREASED A COMBINED 21.4%. ALL THIS WHILE THE NUMBER AND QUALITY OF OUR AVAILABLE PLANS HAVE INCREASED.

OUR SUCCESS IS THE RESULT OF HARD WORK AND TOUGH MANAGEMENT. AND OUR CONTINUING SUCCESS IS BASED ON FOUR MAJOR FACTORS.

FIRST, OF COURSE, IS OUR SIZE, BOTH THE CAUSE AND THE RESULT OF OUR EFFORTS ON OUR MEMBERS' BEHALF. RIGHT NOW, ABOUT ONE PERSON OUT OF EVERY 10 IN CUYAHOGA COUNTY IS PART OF OUR PLANS. THAT GIVES US SIGNIFICANT PURCHASING POWER IN OUR LOCAL AREA, AND THAT BARGAINING POWER GIVES US THE ABILITY TO NEGOTIATE AGGRESSIVELY FOR OUR MEMBERS!

THE SECOND FACTOR IS ACTIVE AND AGGRESSIVE MANAGEMENT. WE WORK HARD BOTH TO KEEP OUR PLANS OPERATING IN OUR MEMBERS' BEST INTERESTS, AS WELL AS TO STRIKE THE APPROPRIATE BALANCE BETWEEN ADVOCACY FOR OUR MEMBERS AND TIGHT AND PROFESSIONAL PROGRAM MANAGEMENT. IN THE GENERAL HEALTH CARE MARKETPLACE, THERE IS NO ADVOCATE FOR THE INTERESTS OF SMALL BUSINESS.

THE THIRD REASON IS OUR LONG-TERM ORIENTATION. COSE DOESN'T TRY TO BE THE BEST DEAL FOR EVERYBODY EVERYTIME. OUR GOAL IS TO BE THE BEST DEAL FOR THE LARGEST NUMBER OF PEOPLE OVER THE LONG HAUL.

THE FOURTH REASON, AND THE MOST IMPORTANT, IS THAT WE HAVE AN EXCELLENT RELATIONSHIP WITH AN INNOVATIVE AND CREATIVE INSURANCE CARRIER. ALL OUR MANAGEMENT EXPERTISE AND SMALL BUSINESS ADVOCACY WOULD BE FRUITLESS IF WE DIDN'T HAVE A CARRIER WHO WANTED TO DO BUSINESS WITH US, AND RECOGNIZED THAT A GOOD DEAL WITH US WAS IN THEIR BEST INTERESTS AS WELL. BLUE CROSS/BLUE SHIELD OF OHIO, AND ITS CEO, JACK BURRY, HAS TREATED US LIKE A MAJOR CUSTOMER, HELPED US SOLVE OUR PROBLEMS, AND WORKED WITH US TO CAPITALIZE ON OPPORTUNITIES. WE ENJOY A UNIQUE AND IMPORTANT PARTNERSHIP WITH THEM, ONE WHICH HAS BEEN MUTUALLY BENEFICIAL AND PROFITABLE. THEIR COMMITMENT TO COSE IS WHAT MAKES OUR PLAN UNIQUELY SUCCESSFUL.

WE BELIEVE OUR EXPERIENCE CAN BE VALUABLE TO OTHER COMMUNITIES SEEKING TO ADDRESS THE HEALTH CARE CRISIS THROUGH THE FORMATION OF INNOVATIVE PRIVATE-SECTOR PARTNERSHIPS. OUR SUCCESS DEMONSTRATES THAT

SUCH AN APPROACH IS POSSIBLE. IT DEMONSTRATES THE POWER OF A CREATIVE, PROBLEM-SOLVING, MARKET-ORIENTED EFFORT. IT'S FAR FROM PERFECT, BUT IT'S THE BEST THAT CLEVELAND'S SMALL BUSINESS COMMUNITY'S GOT.

Chairman **Oakar**. Thank you.

Brad?

STATEMENT OF BRAD ROLLER, PRESIDENT, SWIGER COIL SYSTEMS, INC., AND CHAIRMAN, COUNCIL OF SMALLER ENTERPRISES

Mr. **Roller**. Thank you, Madame Chairman.

I'm Brad Roller, and I'm the president of Swiger Coil Systems, that's the company that the Congresswoman referred to before. We are a small manufacturing company on Cleveland's west side, and for those of you who have large industrial electrical motors over about 500 horsepower around your home, if you need any coils, please, 362-7500.

Chairman **Oakar**. Would you repeat that phone number?

Mr. **Roller**. I'd like to get that in the record if we could.

Chairman **Oakar**. I saw a few customers raise their hands.

Go ahead, Brad.

Mr. **Roller**. For the record also, we have about 100 employees, and my company pays 100 percent of the cost of health insurance for all of our full-time workers.

I'm also currently the chairman of the Council of Small Enterprises, and for the past 10 years I've worked with our staff and our professional advisors on the redesign of COSE's health care plans.

John Polk has told you a little bit about how our plans are organized and why they work. I'd like to spend a few minutes talking about what we've learned in the past 10 years about the marketplace in which our plans operate. I know you've heard a little bit so far this morning.

COSE's plans operate in the same marketplace as everybody else's. We enjoy no special protection, subsidy, or other considerations from anybody. And, we believe that the environment in which we operate is essentially not conducive to our success, as you've heard.

Our growth and success has been based on hard work and on our collective determination to overcome some of the real obstacles to the availability and affordability of coverage, and for years we've been told that we can't do what we do here at COSE, and somehow we've managed to do it.

Well, what are some of these obstacles? Most experts cite high prices as the primary reason that coverage is not generally available in small companies, and it's true that small fully insured groups can pay as much as 40 to 50 percent more for coverage than do larger plans, particularly, self-insured plans.

But, we cannot increase the incidence of coverage in the long term, and the long term is important, by focusing on price regulation. High prices are a symptom resulting from multiple regulatory and market-related factors. To deal with this problem in the long term, we have to focus on the causes, not on their collective effect.

The most obvious and widely acknowledged cost-related barrier is State insurance mandates. In Ohio, our plans operate under 14 State mandated benefits, mandates which larger plans can ignore because they are protected from State regulation. We estimate, and no one can tell us for sure, that State mandates add about $10 million per year to the cost of our plans. That's about 10 percent of our members' premium.

Now, some of these mandated benefits are arguably valuable to our plans. Most of them are not. All of them would cost less in the absence of mandates, but we can't do anything about any of them. Not only do they cost us money, but they take away from our ability to negotiate better plans and coverages for our members.

The most important barriers, however, are market related. They relate to an idea which John touched on, and that is that individual small companies have no chance in this marketplace on their own.

In the current marketplace, none of the major players, the hospitals, physicians insurance companies, or the Government have any incentive to help small companies control their cost. The incentives simply run in the opposite direction.

Small companies desperately need an advocate in this marketplace to harness their collective economic potential and enable them to act as customers, not as victims. COSE is such an advocate.

Well, what are some of these market-related problems? Let's start with the administration and sales costs. COSE's administration costs are about 11 percent of premium. The average administrative cost for a large plan is about 6.6 percent of premium. So, our costs are high for a large plan.

But, they are about half of what they'd be without COSE. We don't pay agents a commission, and that keeps our sales costs down, and that's probably another 5 to 10 percent of premium.

So, if you take mandates, administrative costs, and sales costs, that's probably 25 to 30 percent of premium cost.

State laws enable carriers to build administrative costs into their rates. They have no real incentive to control them, and small companies can't negotiate on their own to keep them down. They just have to pay. We've negotiated caps on our rates, and our carriers' profitability is tied to their ability to control their administrative costs. We've given them an incentive to try to control their costs.

Another barrier is information, or, more specifically, the lack of information. Because small group plans are essentially cost-plus plans, carriers don't do a particularly good job of monitoring eligibility or utilization. Rates are set by formulas, and carriers' rate-setting practices are geared toward protecting themselves, not toward being market oriented.

You've heard about another barrier here, medical underwriting. Most carriers use this practice to exclude as many questionable risks as possible. COSE's plans do contain some exclusions, but our underwriting rules are set to enable us to include as many people and groups as we can. Our underwriting rules are much more liberal than our carriers would like, but they work. Some degree of medical screening is necessary, but most insurers do way too much.

Finally, the biggest barrier is the lack of creativity shown by insurers in dealing with the small group market, and the lack of commitment to the market demonstrated by most carriers.

As Mr. Helms has said, insurance companies don't like small groups very much for many reasons, and most aren't in the small group market for very long. Most HMO's [health maintenance organizations] and PPO's [preferred provider organizations] don't even sell to small groups, and when they do the results are rarely successful.

Our members tell us that a couple of big carriers are notifying policyholders that they are just not going to be selling insurance in Cleveland anymore. Maxi-Care's bankruptcy has caused huge problems for small employers. The Better Business Bureau's small group plan has been canceled by their underwriter. Our own Kaiser plan, supported by changes in Federal HMO legislation, has announced a freeze on enrollment.

When carriers can make these kinds of decisions unilaterally, with no advocate holding them accountable, small groups are helpless.

COSE is very fortunate to have our local Blue Cross plan as a partner, and, as John said, they've worked with us over the long haul to our mutual benefit. Our mutual success over the past 5 years or so demonstrates that it is possible to make this marketplace work better without too much government help.

To us, the question isn't whether it is possible, but whether the key players involved really wish to work together to address the causes of high prices and reduced availability of coverage. We are not going to solve this problem overnight, but working together I think we've got a pretty good chance over the long term.

Thank you.

[The prepared statement of Mr. Roller follows:]

COSE
COUNCIL OF SMALLER ENTERPRISES
A DIVISION OF THE GREATER CLEVELAND GROWTH ASSOCIATION

STATEMENT BY

BRAD ROLLER

PRESIDENT, SWIGER COIL SYSTEMS, INC.

AND

CHAIRMAN, COUNCIL OF SMALLER ENTERPRISES (COSE)

BEFORE THE

BIPARTISAN COMMISSION ON

COMPREHENSIVE HEALTH CARE

CLEVELAND, OHIO

JULY 6, 1989

Cleveland
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MADAME CHAIRMAN, I'M BRAD ROLLER. I'M THE PRESIDENT OF SWIGER COIL SYSTEMS, A SMALL MANUFACTURING COMPANY ON CLEVELAND'S WEST SIDE. I'M CURRENTLY THE CHAIRMAN OF THE COUNCIL OF SMALLER ENTERPRISES. AND FOR THE PAST TEN YEARS I'VE WORKED WITH OUR STAFF AND PROFESSIONAL ADVISORS ON THE RE-DESIGN OF COSE'S HEALTH CARE PLANS.

JOHN POLK HAS TOLD YOU A LITTLE BIT ABOUT HOW OUR PROGRAMS ARE ORGANIZED AND WHY THEY WORK. I'D LIKE TO SPEND A FEW MINUTES TALKING ABOUT WHAT WE'VE LEARNED IN THE PAST TEN YEARS ABOUT THE MARKETPLACE IN WHICH OUR PLANS OPERATE, AND ABOUT SOME OF THE MARKET FACTORS WHICH LIMIT THE AVAILABILITY OF AFFORDABLE HEALTH COVERAGE FOR SMALL COMPANIES.

COSE'S PLANS OPERATE IN THE SAME MARKETPLACE AS EVERYBODY ELSE'S. WE ENJOY NO SPECIAL PROTECTION, SUBSIDY OR OTHER CONSIDERATIONS FROM ANYBODY. AND WE BELIEVE THE ENVIRONMENT IN WHICH WE OPERATE IS ESSENTIALLY NOT CONDUCIVE TO OUR SUCCESS. OUR GROWTH AND SUCCESS HAS BEEN BASED ON HARD WORK, TOUGH MANAGEMENT, AND ON OUR COLLECTIVE DETERMINATION TO OVERCOME SOME OF THE VERY REAL OBSTACLES TO THE AVAILABILITY AND AFFORDABILITY OF COVERAGE.

WHAT ARE SOME OF THOSE OBSTACLES? MOST EXPERTS CITE HIGH PRICES AS THE PRIMARY REASON THAT COVERAGE IS NOT MORE GENERALLY AVAILABLE IN SMALL COMPANIES. AND IT IS TRUE THAT SMALL, FULLY-INSURED GROUPS CAN PAY AS MUCH AS FORTY TO FIFTY PERCENT MORE FOR COVERAGE THAN DO LARGER PLANS, ESPECIALLY SELF-INSURED PLANS. BUT WE CAN'T INCREASE THE INCIDENCE OF COVERAGE, IN THELONG TERM, BY FOCUSING ON PRICE REGULATION. HIGH PRICES ARE THE MOST OBVIOUS SYMPTOM RESULTING FROM MULTIPLE REGULATORY AND MARKET-RELATED FACTORS. TO DEAL WITH THIS PROBLEM IN THE LONG-TERM WE MUST FOCUS ON THESE CAUSES, NOT ON THEIR COLLECTIVE EFFECT.

THE MOST OBVIOUS AND WIDELY-ACKNOWLEDGED COST-RELATED BARRIER IS STATE INSURANCE MANDATES. IN OHIO, OUR PLANS OPERATE UNDER 14 DIFFERENT STATE-MANDATED PROCEDURAL AND PRIVIDER-RELATED BENEFITS, MANDATES WHICH LARGER PLANS CAN IGNORE, BECAUSE THEY'RE PROTECTED FROM STATE REGULATION. WE ESTIMATE (NOBODY CAN TELL US FOR SURE) THAT STATE MANDATES ADD ABOUT TEN MILLION DOLLARS PER YEAR TO THE COST OF OUR PLANS. SOME OF THESE MANDATED BENEFITS ARE ARGUABLY VALUABLE TO OUR PLANS; MOST ARE NOT. BUT WE HAVE NOTHING TO SAY ABOUT ANY OF THEM. NOT ONLY DO THEY COST US MONEY, BUT THEY TAKE RESOURCES AWAY

FROM OUR ABILITY TO NEGOTIATE BETTER PLANS AND COVERAGES FOR OUR MEMBERS.

THE MOST IMPORTANT BARRIERS, HOWEVER, ARE MARKET-RELATED. THEY RELATE TO AN IDEA WHICH JOHN TOUCHED ON, AND THAT IS THAT INDIVIDUAL SMALL COMPANIES HAVE NO CHANCE IN THIS MARKETPLACE ON THEIR OWN. IN THE CURRENT MARKETPLACE, NONE OF THE MAJOR PLAYERS---HOSPITALS AND PHYSICIANS, INSURANCE CARRIERS, OR GOVERNMENT---HAVE ANY INCENTIVE TO ENABLE SMALL COMPANIES TO CONTROL THEIR COSTS; THE INCENTIVE SYSTEM RUNS IN THE OPPOSITE DIRECTION. SMALL COMPANIES DESPERATELY NEED AN ADVOCATE IN THIS MARKETPLACE TO HARNESS THEIR COLLECTIVE ECONOMIC POTENTIAL AND ENABLE THEM TO ACT AS CUSTOMERS, NOT AS VICTIMS. COSE IS SUCH AN ADVOCATE.

WHAT ARE SOME OF THESE MARKET-RELATED PROBLEMS? LET'S START WITH ADMINISTRATION AND SALES COSTS. COSE'S ADMINISTRATION COSTS ARE ABOUT ELEVEN PERCENT OF PREMIUM. THE AVERAGE ADMINISTRATION COST FOR LARGE PLANS IS ABOUT 6.6 PERCENT, SO OURS ARE HIGH FOR A LARGE PLAN. BUT THEY'RE ABOUT HALF WHAT THEY'D BE WITHOUT COSE'S ADVOCACY. WE DON'T PAY AGENTS A COMMISSION, FOR EXAMPLE, AND THAT KEEPS SALES COSTS DOWN.

AND STATE LAWS ENABLE CARRIERS TO BUILD ADMINISTRATION COSTS INTO THEIR RATES; THEY HAVE NO REAL INCENTIVE TO CONTROL THEM, AND SMALL GROUPS CAN'T NEGOTIATE TO KEEP THEM DOWN. THEY JUST GET PASSED ALONG. WE'VE NEGOTIATED CAPS ON OUR RATES, AND OUR CARRIERS' PROFITABILITY IS TIED TO THEIR ABILITY TO CONTROL THEI ADMINISTRATIVE COSTS.

ANOTHER BARRIER IS INFORMATION, OR MORE SPECIFICALLY, THE LACK OF IT. BECAUSE SMALL GROUP PLANS ARE ESSENTIALLY COST-PLUS PLANS, CARRIERS DON'T DO A PARTICULARLY GOOD JOB OF MONITORING ELIGIBILITY OR UTILIZATION; RATES ARE SET BY FORMULA, AND CARRIERS' RATE-SETTING PRACTICES ARE GEARED TOWARD PROTECTING THEMSELVES, NOT TO BEING MARKET-COMPETITIVE. THOSE COSTS BEAR ONLY THE MOST GENERAL RELATIONSHIP TO REALITY.

STILL ANOTHER BARRIER IS MEDICAL UNDERWRITING. MOST CARRIERS USE THE PRACTICE TO EXCLUDE AS MANY QUESTIONABLE RISKS AS POSSIBLE. COSE'S PLANS CONTAIN SOME EXCLUSIONS, BUT OUR UNDERWRITING RULES ARE SET TO ENABLE US TO INCLUDE AS MANY PEOPLE AND GROUPS AS WE CAN. OUR RULES ARE MUCH MORE LIBERAL THAN OUR CARRIERS WOULD LIKE, BUT THEY WORK. SOME DEGREEE OF MEDICAL SCREENING IS NECESSARY. MOST INSURERS DO WAY TOO MUCH.

FINALLY, THE BIGGEST BARRIER IS THE LACK OF CREATIVITY SHOWN BY INSURERS IN DEALING WITH THE SMALL GROUP MARKET, AND THE LACK OF COMMITMENT TO IT DEMONSTRATED BY MOST CARRIERS. INSURANCE COMPANIES DON'T LIKE VERY SMALL GROUPS VERY MUCH, FOR MANY REASONS. AND MOST AREN'T IN THE SMALL GROUP BUSINESS FOR VERY LONG. MOST HMO'S AND PPO'S DON'T EVEN SELL TO SMALL GROUPS, AND WHEN THEY DO, THE RESULTS ARE RARELY SUCCESSFUL. OUR MEMBERS TELL US THAT A COUPLE BIG CARRIERS ARE NOTIFYING POLICYHOLDERS THAT THEY'RE NOT GOING TO BE SELLING IN CLEVELAND ANY MORE. MAXICARE'S BANKRUPTCY HAS CAUSED HUGE PROBLEMS FOR SMALL EMPLOYERS. THE BETTER BUSINESS BUREAU'S SMALL GROUP PLAN HAS BEEN CANCELLED BY THEIR UNDERWRITER. OUR OWN KAISER PLAN, SUPPORTED BY CHANGES IN FEDERALHMO LEGISLATION, HAS ANNOUNCED A FREEZE ON ENROLLMENT. WHEN CARRIERS CAN MAKE THESE DECISIONS UNILATERALLY, AND WITH NO ADVOCATE HOLDING THEM ACCOUNTABLE, HOW ARE SMALL GROUPS TO REACT?

COSE IS VERY FORTUNATE TO HAVE OUR LOCAL BLUE CROSS PLAN AS A PARTNER. AS JOHN SAID, THEY'VE WORKED WITH US OVER THE LONG HAUL, TO OUR MUTUAL BENEFIT. OUR MUTUAL SUCCESS OVER THE PAST FIVE YEARS

OR SO DEMONSTRATES THAT IT IS POSSIBLE TO MAKE THIS MARKETPLACE WORK BETTER WITHOUT TOO MUCH GOVERNMENT HELP. TO US, THE QUESTION ISN'T WHETHER IT'S POSSIBLE, BUT WHETHER THE PLAYERS INVOLVED REALLY WISH TO WORK TOGETHER TO ADDRESS THE CAUSES OF HIGH PRICES AND REDUCED AVAILABILITY OF COVERAGE.

COSE
COUNCIL OF SMALLER ENTERPRISES
A DIVISION OF THE GREATER CLEVELAND GROWTH ASSOCIATION

DRAFT

ALTERNATIVES TO RISK POOLING AND MINIMUM HEALTH INSURANCE

Small Employer Health Insurance Availability and Affordability Act

I. Concept

1. The unavailability of affordable health insurance to small employers significantly contributes to the number of uninsured Americans. Of the 37 million uninsured, 70% are either employed or dependents of employees, and more than half the work force is employed by small employers. EBRI, A Profile of the Non-elderly Population Without Health Insurance 7, 5 (May 1987).

2. The House Committee on Small Business recently found that the "primary reason for higher premiums for small business is higher acquisition costs and fixed administrative expenses." The Health Insurance Problem: Alternative Strategies to Expand Coverage Among Small Business, p. 22 ("Alternative Strategies").

3. The Council of Small Enterprises (COSE) of the Greater Cleveland Growth Association has acted as a purchasing group and has successfully made health insurance affordable to 5,000 small employers and over 100,000 employees and their dependents for more than 10 years. COSE has no restrictions for dependents and fair underwriting rules for employees.

4. The COSE program "save[s] about 35% over the cost of comparable coverage" for its small employer members. Alternative Strategies, p. 31.

5. In 1986, Congress adopted amendments to the Risk Retention Act, 15 U.S.C. §§ 3901-3906, to innovatively address the liability insurance crisis facing many companies. Now Congress can adopt a Small Employer Health Insurance Availability and Affordability Act amendment to make a major contribution to the problem of 37 million uninsured and uninsurable Americans, based upon sound principles already contained in the Risk Retention Act and the demonstrated success of the Cleveland COSE program.

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II. Legislative Specifications.

A. Enact the Small Employer Health Insurance Affordability and Availability Act:

1. Define "Small Employers" to be the self-employed; businesses with less than 100 employees, and governmental entities with less than 100 employees.

2. Permit purchasing groups of small employers to (a) purchase health insurance from an insurer licensed in each state and (b) make health insurance available from that insurer nationally on a uniform basis.

3. Include the same preemption provisions presently available to self-insured employers under § 513 of ERISA.

4. Permit purchasing groups of small employers to be organized and operate nationally, rather than be limited to a geographic area. Alternative Strategies, p. 27.

5. Permit purchasing groups of small employers to operate without the current requirement of a "commonality of business interests," other than their "commonality of business interests" as small businesses. Alternative Strategies, p. 27.

6. Make each small employer individually responsible for complying with ERISA's reporting requirements and COBRA's continuation of health insurance provisions, with no additional responsibility or liability by the purchasing group or other small business members of the group.

7. Make conforming amendments to ERISA, the Internal Revenue Code and the Public Health Service Act.

8. Eliminate any other relevant regulatory obstacles.

B. Amend the Internal Revenue Code to provide a 100% deduction for the health insurance premiums of the self-employed. Alternative Strategies, p. 29.

Chairman **Oakar**. Thank you very much, Brad.

I want to ask my friends from COSE how—is every single person that works for a small business that you or part of your group wants to be insured, are they able to be insured? You mentioned medical screening, that you think it's too serious, sometimes they go overboard, these insurance plans.

Mr. **Roller**. Our underwriting rules right now say that if you have 10 or more employees, you are in.

Chairman **Oakar**. It doesn't matter what kind of sickness they have?

Mr. **Roller**. We don't even check. We don't check medical records if you have 10 or more employees.

Chairman **Oakar**. Good for you.

Mr. **Roller**. Our insurance carrier would like that to be 20 or more or 25 or more, and we've convinced them that's not a good idea.

Chairman **Oakar**. Right.

Mr. **Roller**. Under 10, though, you have to fill out medical statements, and you can, in fact, be rejected.

Chairman **Oakar**. Well, let me ask Mr. Galles, do you have—does your organization have, the National Small Business United, do you have a plan for your members?

Mr. **Galles**. We do not. We have explored nearly 60 different insurance companies, looking for a national program that might compare with what COSE has tried to do, and no one has responded to us with any interest in putting that kind of program together.

We do, however, have a program for individual employees of our member firms with Mutual of Omaha Insurance Co., although they still have many of the same underwriting concerns that we all are concerned about here.

Chairman **Oakar**. I could give you some arguments about some of the points that you made about the type of coverage and the regulations and the State requirements and so on, as it's my feeling that very often things that we think in the short term do cost more money, like alcohol and drug abuse programs, and screening kinds of programs, which in the long run will make your people much more productive and really save you money in terms of their accessibility to their own employment. But, I won't do that now, because I think that that is one of the problems with most insurance plans, that they don't deal with prevention, or there's a bias against certain things and you just assume it's going to cost more.

But, let me just say this. You are at least, and I don't even underline at least, offering access to insurance to your employees which we've heard testimony saying that most small businesses can't do it. I mean, they try, but they are not able to do it. Why can you do it here in Cleveland, greater Cleveland, and why can't we do it nationally?

Mr. **Polk**. I don't think that there is anything magical about what we're doing here in Cleveland that could not be replicated in other communities by organizations that wished to.

I think we have a couple of advantages over an organization like National Small Business United, for example, in that we are fundamentally a local organization. People tend to get sick near where they live, and when they get sick they tend to go to their local providers for services.

Our emphasis on the local marketplace here has enabled us to increase our penetration here locally, and has enabled us to make use of the buying power of our members in a collective way, which is unprecedented as far as I can tell around the country.

It is possible, I think, for other organizations to do what we do. We've got a series of proposals that we can talk about that would enable the Federal Government to assist in the replication of those programs if the Federal Government chose to do so.

Chairman OAKAR. Thank you.

Mr. POLK. The question, as Brad pointed out in his comments, from our standpoint, isn't whether it is possible for us to do so, but whether the various interests involved, providers, insurers, business people as well, are prepared to take a step back from their own short term self-interest to establish in the long term a cooperative partnership which is geared at solving these problems. You can't have it both ways. You can't protect your own turf, maintain the status quo, and be innovative.

We have chosen to disadvantage some of our members by forcing them to play by rules which make them uncomfortable, but the tradeoff for that has been access to coverage. Our insurance carriers aren't making as much money as they would like on our plans, but they've got a pretty fair deal.

Our hospital community here is uncomfortable with managed care arrangements and closed panel PPO's, but we know that those work well for our members, and so we are devoted to a managed care setting for maintaining high quality and lower cost for our member companies.

The question isn't whether it's possible to do, the question is whether the players involved are really prepared to solve the problem.

Chairman OAKAR. Mr. Helms, did you want to speak to that?

Mr. HELMS. Well, I just wanted to speak to the issue of multiple employer trusts. The first point is, it's important to realize that insurers already are at risk in the small group market, they take lots of small businesses and group them. That's not new.

There have been lots of efforts to solve this problem by grouping the employer, and I wouldn't want you to have the impression that that alone solves this problem. I am not in any way speaking against the experiment and the effort of COSE to do this, but you've heard a couple other things that they are doing that are also critical. One is that they have a stable relationship with an insurer who wants the long-term relationship with this market, and they are also doing a lot to manage the care that's provided.

Our projects have found that it's not simply enough to group small employers, that price is still the problem. They are also underwriting in the 10 or less group, and in the 5 or less group. We've got employers that are marginal employers, hiring very low-income employees; we don't have employers, such as Mr. Roller has that are paying 100 percent of that premium.

So, there are a number of measures besides simply grouping employers into multiple employer groups which I don't want us to lose sight of.

Chairman **Oakar**. Well, one of the problems you mentioned, and all of you have mentioned so far, is the need for the insurance industry to cooperate. Most people think Blue Cross/Blue Shield is the same nationally; it's not. Every area has a Blue Cross/Blue Shield, and they treat people differently depending on where they are located.

So, what you are saying is, you've found someone in Mr. Berry who would cooperate with you and say, yeah, we want to give it a try.

Did you want to respond, Mr. Galles?

Mr. **Galles**. I think the local nature is especially important, and I do think the management of that local group, however it is put together, is essential.

There is a need for those people who are buying that coverage to have some ownership for the kinds of benefits and the kinds of claims that are covered.

There is one other item here that I think has been left out of the testimony so far. That is, the tax inequities in the system. You may be aware, Congresswoman, that——

Chairman **Oakar**. I'm very aware of your feelings about that.

Mr. **Galles** [continuing]. Sole proprietors and unincorporated entities can only deduct up to 25 percent of their health care premiums. And, as a matter of fact, members of Ways and Means have talked about eliminating that deduction entirely.

If sole proprietors and unincorporated entities could get the same deductions that all corporations get, 100 percent for their health care premiums, you might see a huge number of those firms in the one to five employee range take up coverage where they have not taken it up before.

Chairman **Oakar**. I think that's true. OK.

Ms. Freedman, did you want to tell us what percentage of businesses in this country or Americans work for small business?

Ms. **Freedman**. Approximately 50 percent of all employees in the United States work for small business, and for that purpose we define it as fewer than 500 employees.

Chairman **Oakar**. Fewer than 500 is a small business. And, your statistics that were very interesting to me, are about 5 years old, and you are updating them, is that correct?

Ms. **Freedman**. Yes, we are. Yes.

Chairman **Oakar**. OK.

Ms. **Freedman**. We have contracted with a researcher to update those figures.

Chairman **Oakar**. And, you are going to—when we have the update of that?

Ms. **Freedman**. The one study that is going to look particularly at 16-year-old's and younger will be finished, hopefully, by the end of this month.

The study that's going to update our general study will take a lot longer. They've just let the contract, and they have to do the survey work, so that will probably be about a year until we have those figures.

Chairman **Oakar**. Brad, are most of your employees, or maybe, John, because I know you fellows worked on this with others for about, what, 8 or 9 years or so to put this together—are most of your employees women and minorities, would you say, of your membership, or is it hard to break that down?

Mr. **Roller**. We are not allowed to ask them, so I don't know.

Chairman **Oakar**. All right. Well——

Mr. **Roller**. My particular work force happens to be very young, and we have a pretty high percentage of women and quite a few minorities, and I would guess that if we did not pay 100 percent of the premium that a whole lot of them, particularly the young ones who think that they are not going to get sick, and that that car is not going to hit them, would probably opt out.

Mr. **Polk**. We do know as far as the COSE plan in total is concerned that, if you take the 56,000 workers that are in our plans and compare them with a similar group of 56,000 people, that our plan is composed disproportionately of percentages of females, that our population is essentially older, the racial mix is not an issue that it's possible really to track, because insurance companies really don't ask that question very accurately.

But, we do know that there are a whole bunch of things about our group that the experts tell us should be working to our disadvantage, and, that is, as we comment occasionally, why we don't let too many experts too close to our plans.

Chairman **Oakar**. Well, we would certainly want to have it for our record, and we want to thank all of you for your wonderful testimony that's very helpful.

We have two more people, and maybe we could, just to expedite this, do this as quickly as we can, because we have somebody that has to catch a plane.

We'd like to have John Morley, who is the CEO of Reliance Electric here in our area, and Chuck Weller, who is with the Health Policy Coalition, that represents some of the larger businesses, like Eaton, Ameritrust, Stouffer's, et cetera, who will come forward, please.

OK. We're going to do this as painlessly as possible, because I know, John, you have to catch a plane, and if I haven't gotten everybody in here. Paul Woods is also with us, who is the CEO—one of the CEO's at Nestle, we're delighted to have you here, Paul, as well.

John, should we start with you——

Mr. **Morley**. Yes.

Chairman **Oakar** [continuing]. Because of your timeframe?

Mr. **Morley**. Yes.

Chairman **Oakar**. All right John, would you please proceed.

STATEMENT OF JOHN C. MORLEY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, RELIANCE ELECTRIC

Mr. **Morley**. Well, let me, I'll go through the introductions, if I might. I'm John Morley, as you indicated, president and CEO of Reliance Electric, which is a Cleveland-based firm.

Just to reinforce my interest in this area, I'm vice chairman of the board of trustees of University Hospital, and a member of the Visiting Committee at the Medical School at Case, Western Reserve University.

Paul Woods, on my right, is vice president of human resources for Nestles Enterprises, and Chuck Weller, on my left, is an attorney with Jones, Day, Revis & Pogue, and together we represent what we think is a bold and new private sector initiative called Cleveland Health Quality Choice and, as you indicated in the introduction, the Health Policy Coalition.

Let me thank the Bipartisan Commission for this opportunity to present these comments, which really focus on three areas: availability, quality, and efficiency of health care.

As we all know, the cost of health care in the United States is high and continues to increase, for the patients, the employees, or the beneficiaries who receive health care, for the physicians and hospitals who provide health care, and for the employers, public and private, and the taxpayers who pay for the care.

Today, as the CEO of a private payer for employee health care my testimony makes three points. First, we are all very deeply concerned about the problem of access to health care insurance for the 37 million Americans without health insurance. As the cost of health care rises, the problem of access becomes greater.

Second, as indicated from studies within the medical community, that is, their study, we are wasting in this country up to $150 billion annually on unnecessary, ineffective, or suboptimal health care. The staggering number approximates the see of the Federal budget deficit. If we can redirect $150 billion, we can dramatically improve health care access for the uninsured, improve the quality of health benefits for everyone, and gain control over a major factor driving the cost of health care.

And, third, I am announcing today at this hearing an example of a new and unprecedented direction that we all need to take. Cleveland Health Quality Choice is a program to identify and measure quality health care outcomes, to encourage and support quality and efficient health care providers, and, concurrently, to broaden health care access to quality and efficient providers.

Cleveland Health Quality Choice has been initiated by 10 chief executive officers of major American companies here in Cleveland: Ohio Bell; Nestles; Sherwin-Williams; LTV Steel; Ameritrust; BP America; Parker Annifin; the General Electric Lighting Group; Jones, Day, Revis & Pogue; and my company, Reliance Electric. These 10 CEO's are personally stepping forward to make an effort to reform our health care system.

Beginning with this core company involvement, Cleveland Health Quality Choice will grow into a broad regional initiative based on three principles of opportunity. The first is choice. Give the American worker and the American people a greater basis for choice. The second is quality. Give the American people and the medical community the information that does not exist today concerning the quality of health care. And, third, incentives. Make public and private insurance incentives more oriented toward positive outcomes and efficiency.

Today, the insurance reimbursement system pays for the procedures, regardless of the results and the costs. We need to become more efficient and pay for what we do for patients, not what we do to patients. We must move from a pay for service system to a reimbursement system focused on quality and results.

Cleveland Health Quality Choice is proceeding along two tracks. First, we are implementing now health insurance benefit plans that allow employees and their families to choose their health care providers using the best quality cost information that is currently available. And, second, we are seeking to improve this information and the feedback process by developing, in cooperation, and this is a very key point, in cooperation with local hospitals and doctors, a communitywide quality cost measurement system.

The Health Policy Coalition wants to work with Congress to implement the three principles of opportunity—choice, quality, and incentive, and to pursue the new directions of health care policy that we urgently need. If we can redirect the $150 billion, which I mentioned earlier, that is wasted annually on unnecessary or ineffective medical care, we can preserve health benefits for the 210 million Americans that have them, and make them available to the 37 million that do not.

Now, you heard a moment ago from John Polk of the program that COSE has, which is another Cleveland success story, accessible and affordable health care insurance for small enterprises. The Health Policy Coalition has proposed Federal legislation that will help take this Cleveland success to other communities and help reduce the number of uninsured Americans significantly.

We strongly endorse the concept of a number of bills pending before Congress that will significantly increase Federal funding for much needed research on the quality of health care and health care outcomes.

We are urging that three basic provisions be added. First, the research must be made available on a reasonable basis to patients from the outset. Second, the research must be made available to patient demonstration projects which will experiment to find the best ways to disperse the information to the American public. And, third, a little local lobbying, Cleveland Health Quality Choice should be designated as a location for a patient demonstration project.

One of your congressional colleagues, back in 1972, was quoted in saying: "I believe deeply that the American people have been given less say in the area of health care than in almost any other area of American life. In no other area do they have so little choice or control." We believe that health policy is at a critical crossroads, and we think that it is imperative that we make the right decisions, and we look to Cleveland Health Quality Choice, who is representing that bold and new direction that we need to take.

[The prepared statement of Mr. Morley follows:]

HEALTH POLICY AT THE CROSSROADS --
NEW DIRECTIONS FOR THE INSURED AND UNINSURED

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Testimony to the

U. S. BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE

Ameritrust Auditoreum
Cleveland, Ohio
July 6, 1989

HEALTH POLICY AT THE CROSSROADS --
NEW DIRECTIONS FOR THE INSURED AND UNINSURED

I. Witnesses. I am John C. Morley, President and CEO of Reliance Electric Company; Vice Chairman of the Board of Trustees of University Hospitals of Cleveland; a member of the Visiting Committee of the School of Medicine at Case Western Reserve University, and a member of the Board of Directors of United Way Services of Cleveland.

With me today are Powell Woods, Vice President of Human Resources for Nestle Enterprises, and Charles Weller, an attorney with Jones, Day, Reavis and Pogue.

We represent a bold new private sector initiative called Cleveland Health Quality Choice and the Health Policy Coalition.

II. Summary. As we all know, the cost of health care in the United States is high and continues to increase:

for the patients and beneficiaries who receive health care,

for the physicians and hospitals who provide the care, and

for the employers and employees, public and private, and taxpayers who pay for the care. For example, 15% of the the average American worker's compensation -- wages and benefits -- now goes to pay for health care. That's a five-fold increase in about 20 years. (See charts).

Today, as the CEO of a private payer for employee health care, my testimony makes three points.

First, we are deeply concerned about the problem of access to health care for millions of Americans, including the 37 million without health insurance. As the cost of health care rises, the problem of access becomes greater.

Second, as indicated by studies from the medical community, we are wasting in this country $150 billion annually on unnecessary or ineffective health care. (See chart). This staggering number approximates the size of the federal budget deficit. If we can redirect this $150 billion, we can dramatically improve access for the uninsured, improve the quality of health care for all, and gain control over a major factor driving the cost of health care.

Third, I am announcing today an example of the bold, new direction that we need to take. Cleveland Health Quality Choice is a program to identify quality health care outcomes, to encourage and support quality and efficient health care providers and concurrently broaden health care access to quality and efficient providers.

Cleveland Health Quality Choice has been initiated by ten CEOs of major American organizations -- Ameritrust, BP America, General Electric Lighting Group, LTV Steel, Nestle Enterprises, Ohio Bell, Parker-Hannifin, Reliance Electric, Sherwin Williams and Jones, Day, Reavis & Pogue. These ten CEOs are personally stepping forward to make an effort to reform our health care system.

Beginning with this core company involvement, Cleveland Health Quality Choice will grow into a broad, regional initiative based on three principles of opportunity:

1) *choice* -- give the American worker and the American people greater choice on the quality and cost of their health care.

2) *quality* -- give the American people and the medical community the information that does not exist today on the quality of health care;

3) *incentives* -- make public and private health insurance incentives more oriented towards outcomes and efficiency. Today, the insurance reimbursement system pays for procedures regardless of results and costs. We need to become more efficient and to pay for what we do *for* patients, not for what we do *to* patients. We must move from a pay-for-service system, to a rembursement system based upon quality, efficiency and results.

III. *Background: Dangers and Opportunities.*

A. *Perilous Times for the Insured and The Uninsured*.

Everyone here is familiar with the staggering problems we face as a nation in health care:

- America spends twice as much as Japan on health care, and 50% more than any other major country -- nearly 12% of GNP; $600 billion in 1989.
- None of these other countries have 17% of the population (37 million in the U.S.) uninsured.
- Medicare, Medicaid and private health insurance plans face ominous short-term and long-term financial problems.

-- Employee and retiree health care costs are out of control.

-- The elderly are largely without protections against the high costs of long term care.

-- Approximately $150 billion of our annual health care expenditures are wasted.

-- The medical community and patients are increasingly burdened with outside intervention by public and private payers.

B. Three Principles of Opportunity for New Directions.

1. Choice. Few workers know that 15% of their compensation goes to health care, and few Americans know that 12% of the GNP goes to health care. Thus there is a great opportunity to give the American people -- worker, patient and taxpayer -- a direct choice in the quality and cost of their health care.

2. Quality. It is now clear that there is precious little scientific information available to patients and the medical community on what medical treatments work best. Thus there is another great opportunity to do the research on quality, and to make it available to patients and to the medical community.

3. Incentives. Public and private health insurance in the U.S. is still plagued with the wrong incentives. We estimate that about 80% of the American people receive their health insurance benefits in ways that encourage overutilization and inefficiency, rather than in ways that encourage doctors and hospitals to provide the best quality care at the lowest cost. Thus there is a third, great

opportunity, incentive reform.

Combined, these three opportunities provide a new direction for American health care, and will give the American people new choice and control over their health care.

IV. New Directions: Action

1. Cleveland Health Quality Choice. Cleveland Health Quality Choice is proceeding on two tracks at the same time. First, we are implementing, now, health insurance benefit plans that allow employees and their families to choose their health care providers using the best quality/cost information that is available today. Second, to improve this information and feedback process, we are developing in cooperation with local hospitals and doctors a community-wide quality/cost measurement system.

2. Partnership with Congress. The Health Policy Coalition is willing to work in partnership with Congress to implement the three principles of opportunity and to pursue the new directions in health care policy we so urgently need. If we can redirect the $150 billion that is wasted annually on unnecessary or ineffective medical care, we can preserve health benefits for the 210 million Americans that currently have them, and improve access for those that do not. Two examples of the partnership we propose are discussed next.

3. COSE Bill -- Building on Success. You heard John Polk testify earlier today about a Cleveland success story. COSE provides health insurance benefits for 100,000 Cleveland-area employees that work for small employers and their families.

Nationally, the largest group of uninsured Americans are affiliated with small employers. The Health Policy Coalition has proposed federal legislation that will help take this Cleveland success to other communities, and help reduce the number of uninsured Americans significantly. (See Health Policy Coalition testimony, "Federal Risk Pool Legislation for the Uninsured: Ominous Risks, Better Alternatives").

4. Federal Funding of Quality Measurement Research. We strongly endorse the concept behind a number of bills pending before Congress that will significantly increase federal funding for much needed research on the quality of health care. (See Health Policy Coalition testimony, "New Directions in Health Policy -- Federal Legislation to Expand Medical Quality Research").

However, we urge that three basic provisions be added. First, the research must be made available on a reasonable basis to patients from the outset. Second, the research must be made available to patient demonstration projects which will experiment to find the the best ways to disperse the information to the American public. Third, Cleveland Health Quality Choice should be designated as a location for a patient demonstration project.

V. Conclusion. Fundamentally, the principles of opportunity and choice we see are rooted in the American Revolution we so proudly celebrated just two days ago. Their applicabilty to health care was forcefully stated in 1972 by Senator Kennedy:

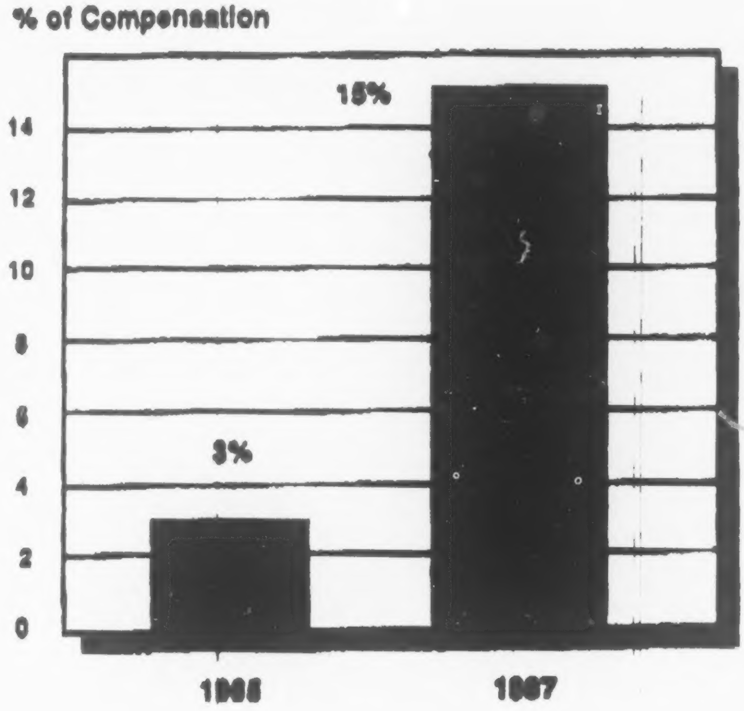
> "I believe deeply that the people have been given less say in the area of health care than in almost any other area of American life. In no other area do they have so little choice or control."

On this point, we strongly agree with Sen. Kennedy. The American people have far too little choice or control over the cost and quality of their health care. We believe that health policy is at a critical crossroad. It is imperative that we make the right decision. Cleveland Health Quality Choice represents the bold, new direction that we need to take.

CEO STEERING COMMITTEE
CLEVELAND HEALTH QUALITY CHOICE

1. Chairman, Mr. Morley, Reliance Electric
2. Mr. Bell, Ohio Bell
3. Mr. Biggar, Nestle Enterprises
4. Mr. Breen, Sherwin-Williams
5. Mr. Hoag, LTV Steel
6. Mr. Jarrett, Ameritrust
7. Mr. Mosier, BP America
8. Mr. Parker, Parker-Hannifin
9. Mr. Opie, General Electric Lighting Group
10. Mr. Pogue, Jones, Day, Reavis & Pogue

How Much of an Employee's Compensation Goes to Health Care



Source:
Charles D. Weller
Health Policy Coalition
Jones, Day, Reavis & Pogue
Cleveland, Ohio

THE RANGE OF MEDICAL UNCERTAINTY:
A $150 Billion Opportunity

Eugene Robin, M.D., Stanford University:

"America's . . . annual healthcare bill could be cut by 30 percent . . . if unnecessary medical and surgical tests, treatments, and procedures were discontinued."

David Eddy, M.D., Duke University:

"We are wasting from 10% to 30% of our resources . . . in terms of doing things that are either not worthwhile at all or are relatively inefficient compared to other things we might do."

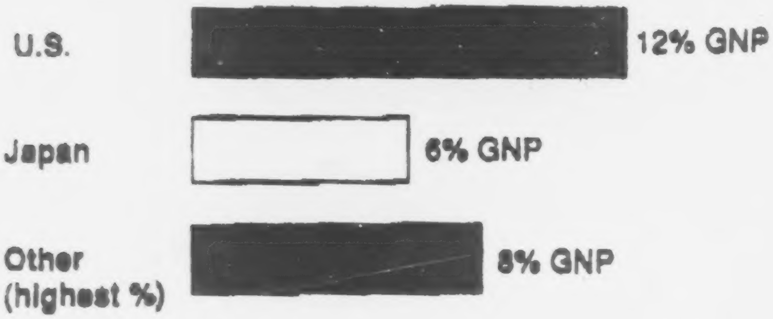
Arnold Relman, M.D., *New England Journal of Medicine*:

"I have long held the opinion, based on wide experience as a consultant and teacher in internal medicine, that more prudent choices by physicians could probably reduce expenditures for drugs, tests, procedures, and the use of hospital facilities by at least 15 to 20 percent—without any loss of medical effectiveness. Lack of available information about the relative effectiveness of new technology and inadequate education of practitioners are partly to blame for this overutilization of medical resources, but the economic inducements of an insurance-based, fee-for-service reimbursement system surely play an important role."

Source: Charles D. Weller
Health Policy Coalition
Jones, Day, Reavis & Pogue
Cleveland, Ohio

U.S. HEALTH CARE COSTS
VS.
OTHER MAJOR COUNTRIES

- ✓ 100% more than Japan
- ✓ 50% more than any other major country
- ✓ 37 million uninsured (none in other countries)



HEALTH CARE COSTS (% GNP)

Source: Charles D. Weller
Health Policy Coalition
Jones, Day, Reavis & Pogue
Cleveland, Ohio

Chairman OAKAR. Thank you very much, John, and if you have to leave, I'll call on the other individuals and maybe they can answer a question or two.

I'm just going to ask you one quick question before you have to leave, and, understandably you do. You mentioned that your own background, I know I'm aware of the fact of your affiliation with University Hospital and Case Western Reserve Medical School. I have a nephew that graduated from there, it's a fine school.

Are doctors going to like your ideas on these—some of these problems?

Mr. MORLEY. That's why I have these two fellows here. It's, perhaps——

Chairman OAKAR. I mean, is it tight fisted, you know, no fuss/no muss kind of program. I'm delighted to hear your call for research, which we have really neglected to think of over the past decade or so; we've just really been remiss in that area, and I'd be happy to lobby for a demonstration project for our area, you better believe it.

But, let me just really ask you, who is going to be opposed to this kind of an announcement that you just made today?

Mr. MORLEY. Well, Powell and others have worked very closely with the Greater Cleveland Hospital Association to begin to introduce this cooperative effort, and I think that the—I guess, really, the two basic characteristics that will promote some cooperation, first is our effort to assure that as we go through the development of a measurement system, we will do all that we can to get their participation and input, and to make it fair.

And then the second issue will be that I think we pretty much have convinced them that we have to do something, and that we would much prefer to do it with them than without them.

Chairman OAKAR. So, you've had dialog with the various hospitals and so on that you are plugging into?

Mr. MORLEY. Yes.

Chairman OAKAR. Well, that's important.

Let me now call upon Mr. Weller. Did you want to go next, Chuck?

Mr. WELLER. Well, we were just here to answer any questions you might ask.

Chairman OAKAR. Oh, all three of you?

Mr. WELLER. Yes.

Chairman OAKAR. OK. So, that's the statement for all of you.

Mr. WELLER. Yes.

Chairman OAKAR. Ed, did you want to ask a question?

Mr. HOWARD. It may be a bit more caustic than you want to try to take on, but you were describing, Mr. Morley, the $150 billion that arguably is waste in the health care delivery system.

If one could channel that into the care for the 37 million uninsured, it probably would pay a whole lot more of the bill than we need to have paid, and the question is, a lot of people who are getting that $150 billion don't consider it waste, and how are we going to make sure that it gets channeled back to serve the purpose that you described the need so adequately?

Mr. MORLEY. Well, I think that's an excellent question. I think it really goes to the heart of the issue.

A premise is that there's a lot of medicine being practiced today that shouldn't be, and if that premise is correct, then there are a number of patients who are the recipients of that bad care. So, I think there is at least a commonality of interest that says that if we can move that group from poor care to proven measurable quality care, based on outcome, that they will benefit.

Second, the concept behind this program is one of incentive, which would be to create programs that support those institutions that provide quality health care. The inference, of course, is that we don't support those that do not provide quality health care.

Mr. HOWARD. Can I just ask either you or one of your colleagues to be a little more specific, to the extent that physicians control the allocation of so much of our health care dollar, whether it is in hospitals or in their own offices, or in the tests they prescribe. How might a scheme like this reward the kind of quality care that you are trying to promote, or, put another way, what kind of sanctions would you have?

Mr. WOODS. Well, there's a central and a complex issue that has to do with the relationship between the physician and the hospital, and the institutional provider and the physician provider, and what our experience has been thus far, in trying to describe our efforts to the Academy of Medicine and to particular physicians, in general, there is a kind of an emotional response, and then there's, I think, a more logical response, really, and a realistic response. In one sense, you are threatening autonomy, and to some extent you are threatening income and control, and nobody likes to have that take place.

On the other hand, we've found that physicians, and especially the more thoughtful physicians in reflecting on this, realize that with an overabundance of physicians and an overabundance of capacity and hospitals, some kind of an economic shakeout has to occur.

Our plan would be to try to provide incentives such that it occurs in favor of the high quality providers, for instance, necessarily just the cheap providers, for example, that we would basically like to see the best of medicine, both physician and hospital, survive and prosper, and to let the shakeout occur along the lines of eliminating those which are not providing the highest quality results.

Our effort is not so much to try to eliminate bad apples or outliers, because we don't think that's the problem. Our effort is to try to provide the information that would move the mainstream of medical practice up a little bit, rather than try to so-called, get rid of just the bad ones, because we don't think they are really the problem.

Chairman OAKAR. Thank you all very, very much.

We have one panel of individuals now with their stories, and then we are going to have an audience shift to accommodate some of the people who haven't had a chance to go in.

So, we'd like to call on Susanne Dotson, John Hexter, Gary Stansbury, and Donald Wilson, if you would come up, please, we're delighted. Thank you very much, gentlemen, for being here, Susanne, thank you for being here, and Gary and so on.

And then, we'll have individual panelists who will be talking about long-term care, and we know we have some lovely children here. We are really grateful that you could bring your children with you, and the people involved who need this type of care, because I think individuals really demonstrate the anecdotal evidence that we need, that there is a problem out there, you know.

So, Susanne, I know that you have a time schedule problem, and, listen, I have to tell you, I am very sensitive about the fact that it's difficult to get individuals. I know we have some family care providers here, individuals who are talking about their own experiences. That's not easy to do, but we can't do it without you if we want to change public policy. So, I want to thank you very much, Susanne. We'll let you start off because you have a time problem as well. Thank you for being here.

Ms. DOTSON. Thank you.

My name is Susanne Dotson. I'm a manufacturers representative for Hampton Products.

Chairman OAKAR. Could you pull that just a little closer, hon?

Ms. DOTSON. A little closer?

Chairman OAKAR. Thanks.

Ms. DOTSON. Can you hear me now? No? Talk louder? How's that?

Chairman OAKAR. OK, that's better.

Ms. DOTSON. OK.

STATEMENT OF SUSANNE DOTSON, MANUFACTURERS REPRESENTATIVE, HAMPTON PRODUCTS

Ms. DOTSON. My name is Susanne Dotson. I'm a manufacturers representative for Hampton Products, which deals in the sale of office furniture.

Until about 6 years ago, I was an interior designer, and I had been for 9 years. I realized I could do a better job selling to other people, so I decided to start my own business. I'm now a sole proprietor and doing very well. Last year, I grossed about $72,000, which should have left me very well positioned to provide for myself and for the future, and to have money to expend on my business.

That would have been true except for one major problem. Because I am a sole proprietor of a small business, and because I've had some medical problems in past years, I cannot get health insurance.

Chairman OAKAR. Wait a minute. You said you can't get health insurance.

Ms. DOTSON. No, no. I have been rejected.

Chairman OAKAR. You have been rejected. OK.

Ms. DOTSON. Yes, yes. I will read you my letter, my rejection letter.

Chairman OAKAR. All right, a little louder, though, because I think this——

Ms. DOTSON. OK.

Chairman OAKAR [continuing]. You are who we are talking about.

Ms. DOTSON. OK, I'll talk louder.

Chairman OAKAR. See, so many people think that the people we are talking about are just the poor. The fact is, there are many uninsurable people in this country, unfortunately, and Susanne is brave enough to come forward and tell us a little bit about it. We need you, you know, so I want to make sure everybody hears your testimony.

Ms. DOTSON. Let me tell you, I'm 45 years old. In my thirties, I developed some gynecological problems, they are not life threatening by any means, but they were persistent. My problems were no more severe than a lot of other women face, probably 5 to 10 million have the same kind of problem I have.

I did require ongoing medical care. I worked with my doctors to avoid the surgery that probably cures it the quickest, and that's a hysterectomy, which I did not want to face. As I age, my problems will resolve themselves.

Until last year, I received my medical health care through my spouse's insurance, Blue Cross/Blue Shield, and I had had that for approximately 20 years. He was a teacher in a public school here in the Cleveland area. Last year we were divorced, and I knew about the law that provided health care for me, the COBRA, even though it's a short term, it's meant to last for, as I understand it, for 3 years, until after the divorce, at which time you then have to find your own.

Chairman OAKAR. So, it's a transitional plan.

Ms. DOTSON. Right.

Chairman OAKAR. Right.

Ms. DOTSON. It's nothing that's going to be permanent.

Chairman OAKAR. Right.

Ms. DOTSON. He had remarried, and I felt I wanted to be free from him, so I felt that I could get health insurance, it's no problem, I'm a relatively healthy person, and I had had insurance all these years. I was very, very wrong.

If I'd have known then what I know now, I would not have dropped that particular plan, although, as I see it now, I probably would have had to face this sooner or later.

I applied through COSE, the plan with the Blue Cross/Blue Shield for single coverage for myself. As I said, I had been insured by Blue Cross/Blue Shield, and I had no reason to believe they wouldn't accept me.

I got this letter a couple of weeks ago and it says, "Ms. Dotson: In response to your request * * *," and I'll just highlight what was said to me, "* * * the Small Group and Individual Underwriting Department has determined that your group cannot be accepted at this time due to the presence of medical conditions. Decisions to accept or reject applicants are made upon the basis of information supplied to the applicant and an evaluation of the degree of the risk associated with any reported condition * * *," and they say: "The information provided to Blue Cross/Blue Shield is held in confidence, and we honor your confidentiality. If you wish to * * *," I want to read this one part: "If you wish to appeal Blue Cross/Blue Shield, you may call * * *," and they gave me a telephone number, and I did, indeed, call them to find out what my alternatives were.

Well, I was really shocked and very surprised. I couldn't understand—I could understand being charged more money, there are people who have a lot of car accidents, and are put in a high-risk group—I was uninsurable.

The other thing is that, I had been insured by these people, and, surely, they could find me, with my Social Security number, they could have found me with my husband's group, but they didn't.

I am now looking for alternatives, perhaps, Kaiser HMO, if that is not closed to me, is a possibility, but I'm really scared. I have—I am uninsurable and I cannot protect myself, and the only person who makes an income for me is me.

I can go bare and hope that nothing happens, or the other possibility is simply to leave this field, which I enjoy doing, and go back and work for a corporation that would provide me coverage.

It's sort of ironic in a country that encourages women and minorities to go forth and to take care of themselves, and they celebrate us as small businessowners, I don't really have a lot of choices.

I've asked the Commission to help me, and others like me. I don't need help from anybody to make a living for myself. I can do that, and I have done that very well. I don't ask them to provide health care for me. I am prepared to pay what I need to pay to insure my house. But, I ask you to build a system where people like me, with some health problems, who are anxious to provide for ourselves, can get coverage.

I don't know what kind of a system that could be, but I do need your help. As a small businessperson operating alone, I can't do this by myself.

Let me raise one last issue, and, that is, as a sole proprietor, and I heard this spoken before, I cannot deduct more than 25 percent of the premiums as a business expense. Again, it's another irony. If I were in a corporation, I could deduct 100 percent. If I employed other people, I could also deduct their premiums as a cost of doing business, but I cannot do my own. I can deduct the cost of my car, of my home office, of my furniture, and my business travel, but I can't deduct the one thing that really protects me and preserves my most important asset, my health, and for health insurance.

I guess I'm asking you to help fix this situation. We sole proprietors should not be treated any differently than any other company, or valued any less. Please, give us 100-percent deductibility on our insurance program.

Is there any other questions I can answer?

Chairman **Oakar**. Well, I'm going to ask you a question now, since I know you have to leave, correct?

Ms. **Dotson**. Yes, surely.

Chairman **Oakar**. So, in other words, here you are, you were insured when you were married to your husband under a certain plan——

Ms. **Dotson**. Yes.

Chairman **Oakar**. Blue Cross you mentioned, for the record, and you got divorced, and you are head of your own household——

Ms. **Dotson**. Yes.

Chairman **Oakar** [continuing]. You are able to support yourself, you make a pretty good salary by most standards, but you can't get insurance because you have some kind of a chronic problem that is not life threatening, but it's there.

Ms. DOTSON. Right, that's correct.

Chairman OAKAR. And, you are a member of COSE?

Ms. DOTSON. Well, I was going to join. I found out about that by being able to apply for the health insurance, but, no, I am not to date.

Chairman OAKAR. You are not. Well, it would be interesting to see if you pooled in with them, whether or not you could get insurance, because I think——

Ms. DOTSON. Well, that's who I applied through. When I called Blue Cross/Blue Shield, they are the ones who told me that the only way they would work with an individual is going through COSE. So, I called the COSE people, and they gave me the information, and I went ahead and applied to Blue Cross/Blue Shield, not knowing that I had to be a member of COSE, they didn't tell me that to begin with. So——

Chairman OAKAR. You are part of the 36 million people we are talking about, and I'll bet most people wouldn't think of your type of situation, you know?

Ms. DOTSON. Right.

Chairman OAKAR. But, it's not very uncommon. There are a lot of people in the same situation you are. So, you are willing to pay whatever it takes, to whatever degree you can get your insurance.

Ms. DOTSON. Within a reason. Obviously, I cannot pay $500 a month——

Chairman OAKAR. Sure.

Ms. DOTSON [continuing]. Or $1,000 a month. No one has that kind of money, expendable income to provide for yourself that way.

Chairman OAKAR. Well, the sole proprietor, you know, in other words somebody within—in your own business, where you are making your own salary, and the independent contractor, those types of people, most of whom happen to be female, I am sensitive about it, and I am very grateful for your testimony.

Let's see what happens, and see how maybe COSE can help you. By joining it, maybe you can be plugged in with the plan. Maybe by making this part of the record, we'll see if there is some sensitive insurer out there who will give this fine person a break. Right?

Ms. DOTSON. I'll mention your name. Maybe I can get something.

Chairman OAKAR. That will get you 2 cents. But, I don't know about my name, I just think that this is a problem that for our record, you know, we wanted to have Susanne covered.

Thank you very much.

Ms. DOTSON. Thank you for your time. I have to leave.

Chairman OAKAR. I know you have to go, and thank you very much.

So, Brad, I see Brad out there, talk to Brad, he's the president of COSE, and I'll bet he's going to help you out.

Ms. DOTSON. OK, thanks.

Chairman OAKAR. Thank you.

We're going to now turn to John Hexter, who is president of a very fine small business, and John's going to tell us his situation in terms of how you determined that your employees needed health insurance. Thanks for being here.

STATEMENT OF JOHN HEXTER, PRESIDENT, INFORMERIFIC/HEXTER & ASSOCIATES, INC., AND BOARD MEMBER, COUNCIL OF SMALLER ENTERPRISES

Mr. **Hexter**. Thank you, Mary Rose.

My name is John Hexter, and I'm president of InFORMerific/Hexter & Associates, a business forms and printing distributor with 13 employees. Incorporated in 1963, Hexter & Associates is a family-owned business. I represent the second generation. We'll do about $1.2 million in 1989.

I joined the company in 1974, after a career in management with the U.S. Postal Service. I have served as officer in charge of the Charleston, WV, Post Office.

Since 1976, I've been president of Hexter & Associates. My father continues to be a very active and vital part of the business. Retirement has permitted him to cut back his workload to about 60 hours a week.

There never has been a question of whether or not there would be health insurance for our employees. Not only has the marketplace for good workers demanded that we offer such coverage, but we would not allow ourselves to be uncovered, and we, therefore, would never allow our workers to be uncovered.

Using necessity as a background, we have tried to cope with the increasing costs of such coverage in a variety of ways. Of course, we joined COSE for the health insurance coverage provided through Blue Cross. There was no underwriting exclusion at the time, a time when we had an employee with Lupus, a blood disorder which required dialysis. I should note here that the dialysis was covered by Medicare, because her treatments were three times a week. She could have easily gotten by with dialysis only two times a week, but the strange and misguided provisions of the Medicare Act, which require three times a week visit in order to qualify for coverage.

Donna became the litmus test for our continuing search for economic coverage. Once again, I must reiterate that there never was any question about whether we would provide coverage, only how much we could pay. We churned the market fairly regularly in the mid to late 1970's. One time we had an Aetna policy, another time we were covered through Massachusetts Mutual. I can't place a price on the cost of Donna's condition to us, since we never made a move unless the policy included a no-gain/no-loss provision, so that Donna was protected. As I said, she became a litmus test. We were not a desirable risk, needless to say.

In the spring of 1981, shortly after Donna was rushed to the hospital for some blood tests because a kidney match had appeared on the National Donor Exchange, it was discovered that not only did the kidney not match, but she had cancer also. What an awful time it was in our office, first shock, and then surgery, followed by chemotherapy and radiation treatments. By late fall, Donna could barely drag herself to work. Staying home was hopeless and depressing, and at least at work when she felt well enough, she was a joy and an inspiration. We never knew which Donna would show up for work, but we knew she would be there.

Her last visit to the hospital was heart wrenching and bizarre. Her pain was controlled by intravenous painkillers, which were leeched out of her blood each time she was dialyzed, resulting in a roller coaster of pain and relief repeating after each dialysis treatment.

Donna finally pulled the plug, having decided on a Friday there would be no more dialysis, she sealed her own fate. We all visited her in the hospital on the following Monday, those of us who could face that situation, to say goodbye. She was dead by the following Thursday.

Donna's death changed the way insurers looked at our group. We became somewhat more attractive. After a couple of years of unconscionable rate increases in the early 1980's, we renewed our COSE coverage, first for some rate stability, and, second, for some all around choices, HMO's and PPO's as result of Federal legislation were becoming available to smaller groups, and so was comprehensive care with some responsibility shifted to employee deductibles.

We never intended our insurance to provide well care, but rather to provide catastrophic protection. It's important to note that all of us are covered by the same policy. We would not cover our employees with any lesser coverage than we would want for ourselves.

COSE has provided a wide assortment of options, and we have employees in the PPO, as well as the Kaiser HMO, and the Blue Cross comprehensive coverage.

In 1986, one of our employees was rushed to the emergency room of St. Vincent's Medical Center with a heart attack. He had emergency bypass surgery, which, surely, saved his life. Our health insurance coverage worked as we had intended. Ramundo retired and subsequently returned to the Philippines, where he has since died. His daughter works for us today, as she did before we hired her father.

Unfortunately, Ray's experience in 1986 and 1987 caused our company to be placed in the category which penalized our rates an additional 35 percent. Ray has died and we continue to pay a surcharge because of a deceased employee. The penalty rate on our health insurance amounted to something over $5,400. When that is added to the losses we suffered in both 1987 and 1988, we have a condition which has not permitted us to provide raises to our very deserving and loyal workers. They know why, but the knowledge doesn't permit them to feed their families any better at this time. They are paying for the penalty rate, which Mr. Estogoi's heart attack caused.

Since health care insurance was not an option with us, we never asked our employees if they would prefer more cash and less insurance. We know what their choice would be, and we simply couldn't permit them to expose themselves to the risks of the uninsured.

Our losses mean that we have not paid any Federal taxes these past 2 years. Certainly, the General Accounting Office has no calculation which represents the cost of lost revenue from businesses which fail to thrive, regardless of the reason.

There is a crisis in America relating to who pays the health care bills. We feel that very acutely at Hexter & Associates, because we have made a firm stand to not be unprotected. There is a cost of that decision, and that cost is magnified, sort of like a reverse economic multiplier, by our inability to contribute to the greater good because we've suffered losses, not profits.

I'm amused in a perverse way by the thought that when a general public considers what being in business means, the image that comes to mind is, J.R. Ewing. The prototype entrepreneur in the currency of the day is clearly some sort of social misfit who contributes nothing to society and hardly works. Surely, the foundation of much of the Tax Code, and much of pending legislation dealing with social and family policy issues, is predicated on the need to force greedy business people to do the called right thing. This is especially true in this era of limited and declining public funding.

I suggest that that image is distorted at best. The more nearly correct image might be found in Cheers, not Dallas. We who are struggling in the trenches recognize there are problems which cry out for solution, problems which the whole of our society must address and resolve in a comprehensive and cooperative way.

Much of the legislative debate on health care issues has overlooked the fact that to most of America's small companies, the uninsured are not an abstraction. They are members of our workplace families, real people, with real problems that we must live with and take personally.

Only in the competitive marketplace can I continue to provide employment opportunities for an expanding work force. My only alternative to control costs becomes layoffs and expensive equipment, which may or may not provide for those elusive profits.

If these hearings accomplish only one thing, I hope it will be the acceptance of an appropriate attitude on the part of our political ears toward the many intensely personal and highly individualized reasons which result in the crisis of the working uninsured. The solutions must be tested in the workplace with pilot projects, such as incentives or credits for doing the right thing, or enabling legislation to encourage the establishment of group purchasing options to improve opportunity to spread the risk and control the costs.

Most of the current solutions revolve around cost-shifting schemes, which only seem to place heavier burdens on the insurance plans, which are the only means a small business has available. We cannot reduce medical care costs by legislating lower fees.

Hexter & Associates is all too typical in our wish to do the right thing for our workers, but our government must be careful not to assume that we will do regardless of the cost. We need to gain control over the runaway costs of health care, not abandon it, to providers, insurers, or the government.

Thank you.

[The prepared statement of Mr. Hexter follows:]

COSE
COUNCIL OF SMALLER ENTERPRISES
A DIVISION OF THE GREATER CLEVELAND GROWTH ASSOCIATION

STATEMENT BY
JOHN HEXTER
PRESIDENT, INFORMERIFIC/HEXTER & ASSOC., INC.
AND
BOARD MEMBER, COUNCIL OF SMALLER ENTERPRISES (COSE)
BEFORE THE
BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE
CLEVELAND, OHIO
JULY 6, 1989

Cleveland
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DRAFT JULY 5, 1989

SELECT COMMITTEE HEARING

JULY 6, 1989

MY NAME IS JOHN HEXTER. I AM PRESIDENT OF INFORMERIFIC - HEXTER & ASSOCIATES, INC. A BUSINESS FORMS AND PRINTING DISTRIBUTOR WITH 13 EMPLOYEES. INCORPORATED IN 1963, HEXTER & ASSOCIATES IS A FAMILY-OWNED BUSINESS, I REPRESENT THE SECOND GENERATION. WE'LL DO ABOUT $1.2 MILLION IN SALES IN 1989.

I JOINED THE COMPANY IN 1974 AFTER A CAREER IN MANAGEMENT WITH THE U.S. POSTAL SERVICE IN WASHINGTON, DC. I HAVE SERVED AS OFFICER-IN-CHARGE OF THE CHARLESTON, WV POST OFFICE. SINCE 1976 I HAVE BEEN PRESIDENT OF HEXTER & ASSOCIATES. MY FATHER CONTINUES TO BE A VERY ACTIVE AND VITAL PART OF THE BUSINESS... RETIREMENT HAS PERMITTED HIM TO CUT BACK HIS WORK LOAD TO ABOUT 60 HOURS A WEEK.

THERE NEVER HAS BEEN A QUESTION OF WHETHER OR NOT THERE WOULD BE HEALTH INSURANCE FOR OUR EMPLOYEES. NOT ONLY HAS THE MARKET PLACE FOR GOOD WORKERS DEMANDED THAT WE OFFER SUCH COVERAGE, BUT WE WOULD NOT ALLOW OURSELVES TO BE UNCOVERED AND WE, THEREFORE, WOULD NEVER ALLOW OUR WORKERS TO BE UNCOVERED. USING NECESSITY AS BACKGROUND, WE HAVE TRIED TO COPE WITH THE INCREASING COST OF SUCH COVERAGE IN A VARIETY OF WAYS.

OF COURSE, WE JOINED COSE FOR THE HEALTH INSURANCE COVERAGE PROVIDED THROUGH BLUE CROSS. THERE WAS NO UNDERWRITING EXCLUSION AT THE TIME... A TIME WHEN WE HAD AN EMPLOYEE WITH LUPUS A BLOOD DISORDER WHICH REQUIRED DIALYSIS. (I SHOULD NOTE HERE THAT THE DIALYSIS WAS COVERED BY MEDICARE BECAUSE HER TREATMENTS WERE THREE TIMES A WEEK. SHE COULD HAVE EASILY GOTTEN BY WITH DIALYSIS ONLY TWO TIMES A WEEK... BUT FOR THE STRANGE AND MISGUIDED PROVISIONS IN THE MEDICARE ACT WHICH REQUIRES THREE VISITS A WEEK IN ORDER TO QUALIFY FOR COVERAGE.)

DONNA BECAME THE LITMUS TEST FOR OUR CONTINUING SEARCH FOR ECONOMIC COVERAGE... ONCE AGAIN, I MUST REITERATE THAT THERE NEVER WAS ANY QUESTION ABOUT WHETHER WE WOULD PROVIDE COVERAGE... ONLY HOW MUCH WE COULD PAY. WE CHURNED THE MARKET FAIRLY REGULARLY IN THE MID- TO LATE-70'S. ONE TIME WE HAD AN AETNA POLICY AND ANOTHER TIME WE WERE COVERED THROUGH MASSACHUSETTS MUTUAL. I CANNOT PLACE A PRICE ON THE COST OF DONNA'S CONDITION TO US SINCE WE NEVER MADE A MOVE UNLESS THE POLICY INCLUDED A NO-GAIN, NO-LOSS PROVISION SO THAT DONNA WAS PROTECTED... AS I SAID SHE BECAME THE LITMUS TEST. WE WERE NOT A DESIRABLE RISK FOR MOST PROVIDERS.

IN THE SPRING OF 1981, SHORTLY AFTER DONNA WAS RUSHED TO THE HOSPITAL FOR SOME BLOOD TESTS BECAUSE A KIDNEY MATCH HAD APPEARED ON THE NATIONAL DONOR EXCHANGE, IT WAS DISCOVERED THAT NOT ONLY DID THE KIDNEY NOT MATCH, BUT SHE HAD CANCER, TOO. WHAT AN AWFUL TIME IT WAS IN OUR OFFICE. FIRST THE SHOCK AND THEN THE SURGERY FOLLOWED BY THE CHEMOTHERAPY AND RADIATION TREATMENTS.

BY LATE FALL DONNA COULD BARELY DRAG HERSELF TO WORK... STAYING HOME WAS HOPELESS AND DEPRESSING AND AT LEAST AT WORK, WHEN SHE FELT WELL ENOUGH, SHE WAS A JOY AND AN INSPIRATION. WE NEVER KNEW WHICH DONNA WOULD SHOW UP FOR WORK... BUT WE KNEW SHE WOULD BE THERE.

HER LAST VISIT TO THE HOSPITAL WAS HEART WRENCHING AND BIZARRE. HER PAIN WAS CONTROLLED BY INTRAVENOUS PAINKILLERS WHICH WERE LEECHED OUT OF HER BLOOD EACH TIME SHE WAS DIALYSED... RESULTING IN A ROLLER COASTER OF PAIN AND RELIEF... REPEATING AFTER EACH DIALYSIS TREATMENT. DONNA FINALLY PULLED THE PLUG, HAVING DECIDED ON A FRIDAY THAT THERE WOULD BE NO MORE DIALYSIS, SHE SEALED HER OWN FATE. WE ALL VISITED HER IN THE HOSPITAL ON THE FOLLOWING MONDAY... THOSE OF US WHO COULD FACE THE SITUATION... TO SAY GOODBYE. SHE WAS DEAD BY THURSDAY.

DONNA'S DEATH CHANGED THE WAY INSURORS LOOKED AT OUR GROUP AND WE BECAME SOMEWHAT ATTRACTIVE AGAIN. AFTER A COUPLE OF YEARS OF UNCONSCIONABLE RATE INCREASES IN THE EARLY 80'S WE RENEWED OUR COSE COVERAGE FIRST FOR SOME RATE STABILITY AND SECOND FOR SOME ALTERNATIVE CHOICES... HMOs AND PPOs, AS A RESULT OF FEDERAL LEGISLATION, WERE BECOMING AVAILABLE TO SMALLER GROUPS AND SO WAS COMPREHENSIVE CARE WITH SOME RESPONSIBILITY SHIFTED TO EMPLOYEE DEDUCTIBLES. WE NEVER INTENDED OUR INSURANCE COVERAGE TO PROVIDE "WELL CARE" BUT RATHER TO PROVIDE CATASTROPHIC PROTECTION.

IT IS IMPORTANT TO NOTE THAT ALL OF US ARE COVERED BY THE SAME POLICY. WE WOULD NOT COVER OUR EMPLOYEES WITH ANY LESSER COVERAGE THAN WE WOULD WANT FOR OURSELVES. COSE HAS PROVIDED A WIDE ASSORTMENT OF OPTIONS AND WE HAVE EMPLOYEES IN THE PPO AS WELL AS THE KAISER HMO AND THE BLUE CROSS COMPREHENSIVE COVERAGE.

IN 1986 ONE OF OUR EMPLOYEES WAS RUSHED TO THE EMERGENCY ROOM OF ST. VINCENT'S MEDICAL CENTER WITH A HEART ATTACK. HE HAD EMERGENCY BY-PASS SURGERY WHICH SURELY SAVED HIS LIFE. OUR HEALTH INSURANCE COVERAGE WORKED AS WE HAD INTENDED. RAYMUNDO RETIRED, AND SUBSEQUENTLY RETURNED TO THE PHILIPPINES WHERE HE HAS SINCE DIED... HIS DAUGHTER WORKS FOR US TODAY AS SHE DID BEFORE WE HIRED HER FATHER.

UNFORTUNATELY, RAY'S EXPERIENCE IN 1986 AND 1987 CAUSED OUR COMPANY TO BE PLACED IN A CATEGORY WHICH PENALIZED OUR RATES AN ADDITIONAL 35%. RAY HAS DIED AND WE CONTINUE TO PAY A SURCHARGE BECAUSE OF A DECEASED EMPLOYEE.

THE PENALTY RATE ON OUR HEALTH INSURANCE AMOUNTED TO SOMETHING OVER $5,400 IN 1988. WHEN THAT IS ADDED TO THE LOSSES WHICH WE SUFFERED IN BOTH 1987 AND 1988, WE HAVE A CONDITION WHICH HAS NOT PERMITTED US TO PROVIDE RAISES FOR OUR VERY DESERVING AND LOYAL WORKERS. THEY KNOW WHY, BUT THE KNOWLEDGE DOESN'T PERMIT THEM TO FEED THEIR FAMILIES ANY BETTER AT THIS TIME. THEY ARE PAYING FOR THE PENALTY RATE WHICH MR. ESTIGOY'S HEART ATTACK CAUSED.

SINCE HEALTH CARE INSURANCE IS NOT AN OPTION WITH US, WE NEVER ASKED OUR EMPLOYEES IF THEY WOULD PREFER MORE CASH AND LESS INSURANCE. WE KNOW WHAT THEIR CHOICE WOULD BE AND WE SIMPLY COULD NOT PERMIT THEM TO EXPOSE THEMSELVES TO THE RISKS OF THE UNINSURED. OUR LOSSES, MEANS THAT WE HAVE NOT PAID ANY FEDERAL TAXES THESE PAST TWO YEARS. CERTAINLY THE GENERAL ACCOUNTING OFFICE HAS NO CALCULATION WHICH REPRESENTS THE COST IN LOST REVENUE FROM BUSINESSES WHICH FAIL TO THRIVE... REGARDLESS OF THE REASON.

THERE IS A CRISIS IN AMERICA RELATING TO WHO PAYS THE HEALTH CARE BILLS. WE FEEL THAT VERY ACUTELY AT HEXTER & ASSOCIATES, BECAUSE WE HAVE MADE A FIRM STAND TO NOT BE UNPROTECTED. BUT THERE IS A COST TO THAT DECISION... AND THE COST IS MAGNIFIED (SORT OF LIKE AN ECONOMIC MULTIPLIER ONLY IN REVERSE) BY OUR INABILITY TO CONTRIBUTE TO THE GREATER GOOD BECAUSE WE HAVE SUFFERED LOSSES, NOT PROFITS.

I AM AMUSED IN A PERVERSE WAY BY THE THOUGHT THAT WHEN THE GENERAL PUBLIC CONSIDERS WHAT BEING IN BUSINESS MEANS, THE IMAGE WHICH COMES TO MIND IS THAT OF J.R. EWING. THE PROTOTYPE ENTREPRENEUR IN THE CURRENCY OF THE DAY IS CLEARLY SOME SORT OF SOCIAL MISFIT WHO CONTRIBUTES NOTHING TO SOCIETY AND HARDLY WORKS. SURELY THE FOUNDATION OF MUCH OF THE TAX CODE AND MUCH PENDING LEGISLATION DEALING WITH SOCIAL- AND FAMILY-POLICY ISSUES IS PREDICATED ON THE NEED TO FORCE GREEDY BUSINESS PEOPLE TO DO THE SO CALLED "RIGHT THING." THIS IS ESPECIALLY TRUE IN THIS ERA OF LIMITED AND DELCINING PUBLIC FUNDING. I SUGGEST THAT THE IMAGE IS DISTORTED AT BEST. THE MORE NEARLY CORRECT IMAGE MIGHT BE FOUND IN CHEERS, NOT DALLAS.

WE WHO ARE STRUGGLING IN THE TRENCHES RECOGNIZE THERE ARE PROBLEMS WHICH CRY OUT FOR SOLUTIONS... PROBLEMS WHICH THE WHOLE OF OUR SOCIETY MUST ADDRESS AND RESOLVE IN A COMPREHENSIVE AND CO-OPERATIVE WAY.

MUCH OF THE LEGISLATIVE DEBATE ON HEALTH CARE ISSUES HAS OVERLOOKED THE FACT THAT TO MOST OF AMERICAN'S SMALL COMPANIES, "THE UNINSURED" ARE NOT AN ABSTRACTION... THEY ARE MEMBERS OF OUR WORKPLACE FAMILIES... REAL PEOPLE WITH REAL PROBLEMS THAT WE MUST LIVE WITH AND TAKE PERSONALLY. ONLY IN THE COMPETITIVE MARKETPLACE CAN I CONTINUE TO PROVIDE EMPLOYMENT OPPORTUNITIES FOR AN EXPANDING WORK FORCE. MY ONLY ALTERNATIVE TO CONTROL COSTS BECOMES LAYOFFS AND EXPENSIVE EQUIPMENT WHICH MAY OR MAY NOT PROVIDE FOR THOSE ELUSIVE PROFITS.

IF THESE HEARINGS ACCOMPLISH ONLY ONE THING, I HOPE IT WILL BE THE ACCEPTANCE OF AN APPROPRIATE ATTITUDE ON THE PART OF OUR POLITICAL LEADERS TOWARD THE MANY INTENSELY PERSONAL AND HIGHLY INDIVIDUALIZED REASONS WHICH RESULT IN THE CRISIS OF THE WORKING UNINSURED. THE SOLUTIONS MUST BE TESTED IN THE WORKPLACE WITH PILOT PROJECTS SUCH AS INCENTIVES OR CREDITS FOR "DOING THE RIGHT THING" OR ENABLING LEGISLATION TO ENCOURAGE THE ESTABLISHMENT OF GROUP PURCHASING OPTIONS TO IMPROVE THE OPPORTUNITY TO SPREAD THE RISK. MOST OF THE CURRENT SOLUTIONS REVOLVE AROUND COST SHIFTING SCHEMES WHICH ONLY SEEM TO PLACE HEAVIER BURDENS ON THE INSURANCE PLANS WHICH ARE THE ONLY MEANS A SMALL BUSINESS HAS AVAILABLE. WE CANNOT REDUCE MEDICAL CARE COSTS BY LEGISLATING LOWER FEES.

HEXTER & ASSOCIATES IS ALL TOO TYPICAL IN OUR WISH TO DO THE RIGHT THING FOR OUR WORKERS. BUT OUR GOVERNMENT MUST BE CAREFUL NOT TO ASSUME THAT WE WILL DO SO REGARDLESS OF THE COST. WE NEED TO GAIN CONTROL OVER THE RUNAWAY COST OF HEALTH CARE, NOT ABANDON IT EITHER TO PROVIDERS, INSURERS OR THE GOVERNMENT.

Chairman Oakar. John, thank you very much for mirroring the sensitivity that you and others have toward your employees and the problems.

Our next witness is Gary Stansbury, who is the owner of IMSCO Corp. of Newark, OH, who is accompanied by Donald Wilson, who is one of his employees.

Thank you, Gary, for being here, and if you'd just pull the mike up just a little bit.

STATEMENT OF GARY STANSBURY, PRESIDENT, IMSCO CORP.

Mr. Stansbury. Thank you, Congresswoman Mary Rose Oakar.

My name is Gary Stansbury, and I am president of IMSCO Corp. in Newark, OH. IMSCO is a distributor of maintenance and production supplies in industry. IMSCO has four full-time employees, including myself.

Chairman Oakar. You are going to have to be a little louder.

Mr. Stansbury. All right.

Chairman Oakar. All right.

Mr. Stansbury. I'm here today because something is terribly wrong with our health care system. Small businessowners need your help to make things better.

Believe me, these are unusual words coming from a person as conservative as myself. A recent personal experience has made me change my mind.

Since I've been in business, I have offered 100 percent paid health coverage for my employees. We have both hospitalization and major medical plans. The premiums were a cost of my business. My employees' health is part of my investment, but it is getting difficult to maintain that investment.

If I can't, the impact won't be just on me, it will fall as well on my employees, like Don Wilson who is with me here today.

What precipitated my health care crisis was the failure of my hospitalization carrier, Medical Benefits Mutual of Newark, to renew my policy. Their reason, we had cost them too much money.

Over a 9-year period, we had paid approximately $25,000 in premiums. They had paid out about $150,000 in hospital bills. I was told we had fallen below their loss ratio.

Unfortunately, Don here, has had some major surgery which he will explain later, and I had heart bypass surgery last year. I was, however, offered an alternative plan, one with less coverage and increased premiums. But, the unfortunate part is that because of requirements of this new plan I cannot pay 100 percent of the premium. Now all employees must contribute part of their salary to the insurance premium.

Just 1 year ago, my health premiums totaled $7,388 per year at no cost to the employee. Today, I will pay $12,352 per year, and my employees must share in the cost.

One of my employees, married with a family, agreed to drop out of our health care coverage and become covered under his wife's insurance. I could do that also, since my wife has family coverage through her work. But, if I drop out, we cannot fulfill the requirements of this new contract, which states that 50 percent of all eligible dependents must also be covered. This adds $208 per month to the premium.

My alternatives are few. I can't go anywhere else because they would try to keep Don and me out of a new policy because of preexisting conditions. I can't let my employees or myself go without coverage. So, I have to take it out of profits, and my employees have to take it out of their salaries, that won't go up because there isn't any money for raises. My prices are pretty much set by the companies from which I buy, so I can't raise prices to make up the difference. All we can do is eat it, as a company and as individuals.

I have submitted on a separate paper a comparison of our insurance costs, and I think you will find the difference is incredible. We are a small company with a gross of less than $800,000 per year. How much longer can I afford these kind of premiums? How many more companies will drop us because we had to use their insurance?

I don't have any answers, but you are the people that can do something, you are the people that can help people like Don and me, and others who are in the same situation. I'm not asking for a handout. I'm just asking for a system that will let me keep my people covered at a cost which I and they can afford.

Thank you.

Chairman **Oakar**. Thank you very much.

Don, do you want to say a few words now about your situation? Just pull the mike toward you there, Don.

STATEMENT OF DON WILSON, EMPLOYEE, IMSCO CORP.

Mr. **Wilson**. My name is Don Wilson, and I work for Gary at IMSCO. My work involves checking in the stock, filling orders for customers, basically, a lot of everything in this small company.

I'm here today because it's important to let you know what's happening in little companies that isn't just affecting the people that own them.

If it wasn't for Gary, I wouldn't even have insurance, and I'm very grateful, you know, to him for having that for us.

Chairman **Oakar**. Sure.

Mr. **Wilson**. Five years ago, I was 24 years old, healthy, didn't have a worry in the world. Well, all of a sudden I started having severe stomach pains, and I had to go into the hospital. Well, when I woke up after surgery, I was told I had no more small intestines. I was going to be on an IV feeding probably for the rest of my life. And, it's very expensive.

I was off work probably 13 months. Gary kept my premiums paid, assured me that my position would still be there when I fully recovered. If it hadn't of been for that, I don't know how I would be able to pay for my medication, my food, you know, the IV feeding to keep me alive. But now, because of my enormous hospital bills, they are wanting to either drop us from our hospitalization coverage, or raise the rates to where we can't hardly afford them, and we're going to have to start paying, and I just don't think it's fair, and I think something needs to be done about it.

Chairman **Oakar**. Well, thank you very much. I think what we're seeing here is the magnitude of the problem, seeing small business people who have had either themselves or their employees with fairly catastrophic situations. In your case, Mr. Stansbury, you had an insurer who dropped your policy. I mean, I even asked my legal counsel here, can you just do that? I mean, are there any guidelines nationally, or is it a State issue?

Mr. **Howard**. In fact, we probably should have the last panel back again. The McCarran-Ferguson Act basically cedes the regulation of the insurance company to the State government.

Mr. **Stansbury**. I consulted an attorney, checked with the State of Ohio Insurance Commission, tough bananas! The policy can be canceled.

Chairman **Oakar**. The limits of the marketplace, huh?

Well, insurance is supposed to insure you for things you hope never happen to you, and you had some things happen to you that you hoped would not happen, but it did happen. I think this is one of the critical problems that we really have to address, and it's especially critical when you are dealing with people who are involved in a similar situation, it appears to me.

In any event, we have Frank Valenta who is going to testify, and I know he's going to tell us about some factory closings in the past, where we've had to try to pitch in for maintaining some of those benefits for the employees. But, John, in your case, you had a situation where you were sensitive toward an employee that was loyal to your company. What would have happened to that employee, do you think, if you had decided, this employee is a burden on the company, and we just can't afford the increase in rates because she's holding us down to an extent. What do you think she would have done?

Mr. **Hexter**. Well, it's interesting, there are two issues that we saw relating to Donna. One was the Medicare Act, and it was just beyond our understanding why—Medicare picked up a big chunk of that bill, so that, in fact, we weren't quite as negative to another insurance carrier, but it picked it up under a flawed pretense, that was that she needed this dialysis three times a week.

Donna weighed 95 pounds soaking wet, and dialysis twice a week was enough according to her doctors, but that didn't qualify her for the Medicare coverage. So, we have the dialysis, the limited availability of dialysis being usurped unnecessarily by Federal regulation. That's just a bad allocation of resources.

But, her husband was a sole practitioner, and he certainly couldn't get insurance. We didn't really have a choice. The absence of insurance on Donna's—the absence of including Donna would have cut her husband off from insurance also.

These are the kinds of things that we have consciously chosen to ignore. We're saying that insurance—we wouldn't have—we wouldn't go across the street without having some kind of insurance, and we wouldn't have our employees do that either.

Chairman **Oakar**. Do you think you gentlemen are typical of—I mean, be honest now, are you fellows typical of the business community in terms of the degrees to which you would be loyal to your employees?

Mr. **Stansbury**. Oh, I believe yes.

Mr. **Hexter**. I don't see a whole lot of my coworkers, cobusinessowners, looking to find a way to avoid that kind of coverage, or to cover themselves only and not their workers. I think that's the exception, not the rule.

Chairman OAKAR. Do you feel the same way?

Mr. STANSBURY. Oh, yes. The people I talked to, especially, and a lot of my customers are machine shops, which are, basically, small businesses, and they are all having the same trouble I'm having, except they haven't had the bad luck that we've had, with two, essentially, catastrophic-type illnesses. So, their insurance is a little bit easier to get than our's.

Chairman OAKAR. Well, I want to thank both of you, all three of you, actually, for your testimony. You add another dimension to the problem. So, thank you very much.

I know a lot of people feel that small businesses don't get a lot of attention. We just whack you away with regulations and things, but the truth of it is, that's one of the reasons why we wanted to have this hearing; it's an important part of our testimony.

So, thank you all very, very much for participating.

We're going to ask our long-term care victims and providers to please come forward, and I'm going to ask Frank Valenta, as well, to come forward. Frank is the president of the Cleveland AFL-CIO. We're proud of our business community. We are also proud of our labor community here in greater Cleveland. Frank is also the director of district 28, United Steelworkers of America. So, Frank, if you would come forward with that panel.

Next we'll have Patricia Davis, Diane Godessa, Kathy Yane, and can we fit Ruth Reinking in as well? Can we fit you all? If we can, that will be great, and then if we can't, we'll have Frank's testimony.

Where's your dear little boy? Where is he? Where's my pal, Alex? There's Alex. He just heard me call out his name. Isn't he a darling? Hi, Alex, how are you? I'd love to have Alex come up, but I guess that's not possible, is it? Maybe when we get to your testimony. Are you Alex's dad? OK. Well, we might have you come up as soon as we get to call on—because we think he's such a good looking guy, that I think our people would like to see Alex, wouldn't you?

Let me call on Frank Valenta, one of the great labor leaders in our area, and, Frank, why don't you proceed with your testimony. Take over the mikes there, Frank.

Mr. VALENTA. Thank you, Congresswoman Oakar, on behalf of the entire labor community.

Chairman OAKAR. Frank, how about moving that pitcher out of your way.

Mr. VALENTA. Sure.

Chairman OAKAR. I can hardly see you. It's a pretty big pitcher, and we're going to keep moving that downward. If anybody can grab that thing.

Go ahead.

STATEMENT OF FRANK VALENTA, PRESIDENT, CLEVELAND AFL-CIO AND DIRECTOR, DISTRICT 28, UNITED STEELWORKERS OF AMERICA

Mr. **Valenta**. On behalf of the entire labor community, we want to thank you and your committee for holding these types of hearings, which certainly could be controversial and, obviously, emotional. I really didn't come down here today to testify, I more or less came down to listen.

One of the reasons why I wasn't sure whether I could be here was because of some very difficult negotiations that we're facing right now with the United Steelworkers of America. What makes the negotiations somewhat impossible is that, as we get to the completion of the negotiations, to start winding up with the discussions that deal with finances, we're always deluged with requests from the company that we should be involved in health care programs, contractual provisions, that would bring about all kinds of changes in the programs as we have them today, that is, where they have copayments and deductibles and the likes of that.

You know, I've heard a lot of testimony here this morning from small business, and I realize that that's basically what your committee is concerned about in these hearings, but whether it be small business or large business, they are all in the same category when it comes to staying in business, and especially as competitive as everything is today with all businesses, because we are now involved in a global market.

It's evident to me that some drastic changes have to be made in our health care programs in this country, because it's got to the point that this is what's making us incapable of competing with our foreign competition, whether it's the European market or the Asian market or whatever it is, we're in competition with them today, and all of these other countries have national health care and we don't.

In the United Steelworkers of America's negotiations with the big steel corporations, somewhere between $23 and $24 an hour is the total labor cost, with half of that cost being for the insurance program, and most of that cost being for health care coverage. I think about $4.30 an hour is just for the health insurance cost, and so it's important that we note this because this is what causes us to be very uncompetitive with our foreign competition.

Right now, we have a free trade agreement with Canada. Canada's wages are comparable, just let's say in the steel industry, the steelworker in Canada makes primarily the same kind of an hourly wage as the steelworker in America, because they are part of our union, and we negotiate this together. The only thing that we can't compete with them on would be their health care costs. So, with the value of the dollar, and the problems we have there with Canada, plus adding the fact that we can't compete with them in health care, how are our American workers going to be the least bit competitive with Canada in this so-called free trade agreement?

So, that's the point I thought was necessary to make here today. Whether it's small business or big business, we are all up against the same problem. I think the only answer to it, and I'm sure everybody in this audience here, as I view them, would probably agree, that beating around the bush won't do us any good any longer, if there's anything we need in this country and we need it today and we need it immediately, it's national health care for all of the citizens.

I thank you.

Chairman OAKAR. OK, Frank. Well, I think you have a little bit of subtle agreement there, but we're delighted to have had you, Frank. I know you have to get back to your negotiations. I honestly don't have any questions for you. I know that one of the things, however, that we had tried to work on—and, ultimately, with the leadership of your union and others—is that we were able to get your retirees their health insurance that sometimes is a problem when companies merge and fold and so on. They often abandon their loyal employees, and, particularly, when we had the chapter 11 problems with LTV. But, has that been reconciled now, the health insurance for all your retirees?

AUDIENCE. No.

Chairman OAKAR. All right, well, wait a minute. Didn't I ask the right question, huh?

Mr. VALENTA. Well, we do have some legislation now to prevent what happened with the LTV retirees some years ago from happening again with any retirees in this country.

Chairman OAKAR. That's right.

Mr. VALENTA. And, that more or less deals with bankruptcy at the time of the filing of a bankruptcy, where a company feels that right then and there they shouldn't continue to pay the premiums for their retirees. That can't happen any longer.

But, only through legislation, you know, I think it's finally got to the point where a lot of Americans are thinking today, this business of, let's get the government off our backs, I think, has turned into a lot of thoughts and opinions today that say, let's have the government protect our backs.

And, thank you very much for having this Commission hearing and allowing me to say a few words here, and we wish you all the luck in the world, Congresswoman Oakar, knowing that you are going to do more than just have a hearing, we know that you are going to take all of the evidence, and whatever is being said here today, back to Washington, DC, and we wish you all the luck in convincing your fellow legislators that it's time for action. We need laws now to protect these people here in America that certainly don't have health insurance coverage.

Chairman OAKAR. Thank you very much.

All right. We're going to now hear from Patricia Davis. Pat, please proceed, and I want you to tell us a little bit about your husband, your three children. You are from Westlake, OH, and we're delighted to have you. If you'd pull that mike a little bit closer to you.

Now, I should say that this panel is concerned with the problem of long-term care. That was one of the bills that some of us supported—Senator Pepper's bill, in particular—and we weren't able to get that passed in the last session, but that is one of the studies that this Commission has to submit to Congress and the President, due to Senator Pepper's efforts. So, we are delighted to hear from all of you today.

So, would you proceed, Ms. Davis?

STATEMENT OF PATRICIA DAVIS, WESTLAKE, OH

Ms. **Davis**. I am Patricia Davis. I'm from Westlake, OH. Congressman Oakar, we are very glad to be here, believe me, I'm very glad to be given the chance to publicly speak out about these problems.

Chairman **Oakar**. OK, push that mike closer to you, and I want the audience to be sensitive, it's not easy for them to tell their stories. Right? OK. Thank you.

Ms. **Davis**. I am 38 years old, and the mother of three beautiful daughters. I live in Westlake, OH. I am here today to share with you what it is like to try to deal with health problems when you don't have any health insurance or totally inadequate insurance.

My first real awareness of our health care system came when I was 30 years old and diagnosed with cancer of the thyroid. I was married at the time, and everything was covered by insurance because my husband had pretty good insurance for a nonunion company in the South.

Not long after that, though, we were divorced, and the children and I were no longer covered by his insurance.

For a short time, I was on welfare and had coverage through Medicaid, but since I do have some education by high school diploma, and some college, I decided that I needed to go to work and support and raise the children to the best of my ability.

The only jobs I could find at that time, were minimum wage type jobs, like McDonald's, nursing homes, that sort of thing. They provided benefits, but you had to work there for such a very long time, usually 90 to 120 days, before insurance was even enacted for a family. They also tried to keep you working part time, so that they didn't have to offer any benefits, and that's still what they do.

I took a job as a nursing assistant in a nursing home. The children at that time were 7, 4, and 2 years of age. The job was low paying, and offered no benefits. We couldn't afford health insurance on my income but, fortunately, at that time we had no health emergencies.

In January 1982, I decided to move back to Ohio. We couldn't have come back at a worse time. Companies were going out of business, it was impossible to find a job in this part of Ohio.

For a time, I had to go back on welfare, and we had some coverage through Medicaid, but it isn't very good—and it's definitely inadequate.

In 1983, I got a job working as a nursing assistant for Upjohn Health Care, which is part of Upjohn Pharmaceutical Corp. They offered health insurance, but I would have had to have paid approximately 35 to 40 percent of my income to pay for coverage for the entire family. At that time, I was making $4 an hour, which was my wage for the next 5 years.

Trying to pay for rent, food, and clothing on that salary was hard enough. We could not have made ends meet if—we wouldn't have been able to make it at all if I had purchased that insurance.

About 5 years ago, I remarried. My husband is also underemployed. There are not a lot of jobs in Ohio working in mobile homes, which is his specialty. The jobs usually don't last very long because of his age and health. Every time he is laid off, we are without coverage, and most of the jobs he gets don't offer benefits, and if they do, it's the same 90 to 120 days waiting period before benefits go into play.

In 1984, my husband was having some health problems, and he signed himself in St. Joseph's Hospital for tests. He was there for 3 days. The bill came to slightly over $2,000. Since we had no insurance, we are still paying off the collection agency for the hospital little by little, as we can.

In 1987, 3 years later, the doctors discovered that I had ovarian cancer. I was experiencing female problems and was in a lot of pain at that time. Major surgery was done, which included a hysterectomy and bilateral oophorectomy. My husband was working at a job at that time that did provide insurance for us. The insurance picked up approximately 80 percent of the over $10,000 bill, which still left us with approximately $2,000 to cover.

Because of the surgery, I was out of work for about 7 months. We were, at that point, down to one salary. This, of course, put a very big financial strain on us.

Then, my husband was laid off again and, once again, we were without insurance, and at this point still are.

My youngest daughter has a problem with severe nosebleeds, because of very thin nasal membranes in her nasal passages she experiences bleeding at times three to four times a week, and in very large quantities. We have taken her to specialists at St. John West Shore Hospital and Fairview Hospital, and, of course, we have the bills now from that, from the emergency room type of situation, and being repeatedly told that there is not much they can do, since we don't have insurance, we can't afford further treatment.

Not long ago, we had to take my oldest daughter to the emergency room——

Chairman OAKAR. That's all right, you just take your time, honey. No problem. You just take your time. We appreciate your telling your story. It's all right. It's OK. We feel very strongly about it, what you've gone through, but, you know what, you are certainly not alone. I mean, this is a national problem. So, your telling this Commission what it is, is very helpful to us, Patricia, and, you know, you let it out. It's no problem for us. OK?

Ms. DAVIS. Anyhow, in fact, May 20, we took my 16-year-old daughter to the emergency room because she was experiencing vaginal bleeding from a tear in the lining that she had been born with, a very bad weakness they said. At that time, she lost about 2½ pints of blood.

The hospital kept trying to tell me in the emergency room that my daughter was stabilized and she was fine and that I should take her home. The fact that I had a lot of nursing school and a lot of medical training behind me, I knew better.

I got a second opinion, and the doctor did agree with me that there was an incredible amount of bleeding that had to be repaired. She was taken into emergency surgery and the repair work was done, but instead of keeping her overnight after losing that amount of blood, they sent her directly home with us in the car.

The bill for the gynecologist who performed the surgery is at this point slightly over $1,000, because she is so anemic from the loss of blood that her iron shots are running $35 per shot, at least twice a week, to get her iron built back up.

The bill from the hospital was over $2,000. We were there a matter of maybe 8 hours. All tolled, we owe over $3,200, and I'm sure the fact that we had no insurance was a factor in the decision to send my daughter home right away, where she proceeded later in the day to pass out and had to be carried to the couch when she tried to walk.

I'm now working in a temporary agency doing office work. They do offer insurance coverage through a temporary benefits program that covers several of the companies like that for temporary employees. I should be getting regular checkups to monitor myself for cancer, but because of my history I should receive a mammogram every 6 months and regular Pap tests and internal exams, but, needless to say, I can't afford them.

My husband has emphysema, and was part of a program at Metro General Hospital that called for regular visits, but because we have no insurance, he really can't afford to go back.

After my eldest daughter's surgery, she was, as I mentioned, very severely anemic, the doctor had prescribed four different medications for her at that time. We had them filled once but can't afford to have them refilled every week.

The children don't get regular dental checkups because we can't afford to go, and even on the coverage offered by the many small companies, they don't usually cover dental.

It's hard to get into a doctor's office if you don't have insurance. If you do get in, after a few visits they start asking for payment on previous visits before they will see you again. They actually do turn you away. After a while, you just can't go back, and you have to pay off the bills as you can afford to.

We are working hard to pay our own way in this world. It doesn't seem right that we should have to compromise our health and the health of our children because our jobs don't provide insurance, and we can't afford to buy the insurance ourselves.

Chairman **Oakar**. All right. Thank you very much, Ms. Davis, for your testimony.

I'm going to go on, and then we're going to ask you all some questions. Is that all right? Does anybody have to leave yet, or can we just keep going?

Our next witness is Diane Godessa, who is going to tell us a very interesting contrast between Canada and the United States in terms of health coverage. And, Diane, I am so glad that our staff found you, because I think this mirrors some of the problems that we face as good U.S. citizens. So, thank you very much for being here.

Mrs. **Godessa**. It's a pleasure.

Can you hear me?

Chairman **Oakar**. Could you move that pitcher out of your way, unless you need some water. I just don't want you to be blocked. Just make sure you get some water.

STATEMENT OF DIANE GODESSA, STRONGSVILLE, OH

Mrs. **Godessa**. My name is Diane Godessa. I live in Strongsville, OH, a suburb of Cleveland, with my husband. We have four children.

Alzheimer's disease has touched my life for the last 12 years. When my mother-in-law in Canada was diagnosed with the disease, I went to our family dictionary to find out what it was. It wasn't listed. Since then, I have learned all too well what Alzheimer's mean.

It has been called the long goodbye, and the never ending funeral. To me, it has been a personal nightmare filled with emotional strain.

In 1982, when my youngest son turned 8, I began to make plans to return to work. Within a few months, my life took a very different path. You see, for the past 6 years, I have been the caregiver for my 71-year-old mother who also has Alzheimer's.

Chairman **Oakar**. So, let me ask you, let me just make sure I understand that. Your mother-in-law, who lives in Canada, has Alzheimer's, and now your mother has Alzheimer's, is that correct?

Mrs. **Godessa**. Yes, that's correct.

Chairman **Oakar**. Who lives in the United States has Alzheimer's?

Mrs. **Godessa**. Yes, that's correct.

Chairman **Oakar**. OK.

Mrs. **Godessa**. The simple task of taking my mother for a neurological workup was an awesome effort. She was a tough-minded, take-charge individual, and my interference was not acceptable. Once the tests were completed, and the diagnosis made, I knew that serious decisions lay ahead. It's been an uphill battle since.

Getting her to stop driving is just one example. She drove down busy streets very, very slowly, and through red lights. She drove with doors ajar or the trunk wide open. She often got lost. When it rained, she didn't know how to turn on the windshield wipers.

Eventually, I was able to have her license revoked, but I had to call the motor vehicle bureau often because she would get another just by saying she had lost the last one.

Finally, we had to sell her car, when even removing small engine parts failed to keep her off the streets.

In reality, I was taking away more than my mother's car, I was taking her life, her independence, her dignity. It was a complete and uncomfortable role reversal. I was the parent and she the child. It was terribly traumatic for both of us.

At the time, mom lived alone 40 miles away. There was only milk in her refrigerator and no food in her pantry. Money was scattered everywhere. Dirty clothes hung about. Clothes and newspapers were scattered across the floor. The doors were left wide open, and the furnace ran continually with the thermostat set at over 80 degrees. A dog had ripped the door screen and jumped in and out through the hole. My mother's hair was in disarray and chopped off in patches, and she was very dirty.

This was not the mother I once knew. She was attractive, meticulous, and bright. I am her only daughter. My father and brother are dead. It was up to me to do something.

Mother wanted to live in her own home, not with me. She fought me constantly. I tried to compromise by moving her to a home close to mine. I went there several times a day and evenings. I did her housework, shoveled her snow, cut her grass, and saw that she was kept clean. I obtained Meals on Wheels, and had the milkman deliver milk and other food items to her, but she resented my interference.

This arrangement lasted only 6 months. The neighbors complained. Mother started night wandering. When the police found her at the Berria Fairgrounds, once again, I had to make decisions I knew would anger her. So, we moved my mother in with us.

I remember how she stood by the front door screaming for help. Everyone said that she belonged in a nursing home, but I could not face that thought. She was healthy, could hold a social conversation, and had been through so much, I felt a nursing home would kill her spirit.

Today, 6 years later, my mother is still with me. She has been bedridden for almost 2 years now. Sometimes she lies quietly talking softly, but, more often, she's in some type of rage. Her mood swings from hysterical laughter, to bouts of tears, to outrage, and paranoia. I rarely have a full night of sleep. I'm often awakened by her outbursts. I go to her and try to calm her fears.

I dress her, wash and feed her, clean up her accidents, do her laundry, cut her hair, nails, and so on. There are days when I have been physically exhausted caring for my family, home, and my mother, only to have her verbal abuse thrust upon me. It is emotionally draining at times, and I do fall apart.

Despite all this work, my mother had always been considered custodial care, and could never receive help from Medicare. My mother has a low-level income, which means most of her needs are supplemented by our finances. Good nursing homes are expensive.

Last fall, I needed major surgery, and mom had to be placed in a home while I recovered. We paid for it, and for the ambulance to get her there and back. She often refuses to eat, and must be given supplemental liquid nutrition, which is very expensive.

There are many expenses related to her care, such as special foods, diapers, bedpads, and other personal items. I rent a hospital bed with a special mattress to prevent bed sores, and a wheelchair.

But, our family has had to sacrifice in other ways. My freedom has been taken away. I am prevented from holding a job and/or going away with my family. I should be looking at colleges for my son, a senior in high school, but cannot. All priorities have changed. My life is sandwiched between my concern for my children and a sense of duty to my mother. My teenagers find it difficult having their grandmother's needs come first. I thank God for my supportive husband.

But, I feel a moral responsibility toward my mother. Before my father died, he asked me to take care of her. My father served in the Navy during World War II, and mom was alone then taking care of my brother and me. I don't want to feel guilt when she dies.

I am one of hundreds of thousands in this country dealing with this humiliating disease. For 4 years, I was coleader of an Alzheimer's support group. Our meetings are filled with the anguish, despair, and financial devastation this disease causes. With just a little help from our government, our loved ones could be better cared for at home, and we caregivers could receive much needed respite services. I believe that many of the tragedies that we read about in our newspapers stem from the hopeless way people live through this difficult disease. Many elderly are alone and feel that no one cares. They don't know where to turn for help, they cannot cope. They become desperate and sometimes do terrible things.

Caregivers and victims need assistance. Their senior years should not be filled with despair.

I thank you.

Chairman **OAKAR**. Thank you very much, Diane, and I want you to be thinking of this, because one of the questions I am going to ask you after we are finished is to tell me a little bit about what you know of how they treated the same type of victim, your mother-in-law, in Canada, what kind of services they have in Canada.

You are 1 of about 1 million—there's about 1 million people, Ed tells me, who have Alzheimer's, and, in fact, I think your Alzheimer's Association Convention is coming to Cleveland this Saturday, here in our area.

Kathy Yane is the mother of Alex Yane, who is 7 years old, and I want you to stand up at least, unless you want to come up and join us. Do you want to come up? You are the father? What is your first name, for our record? Jim? OK.

This fellow has got to be one of the greatest kids. I mean, he has just sat here through this whole hearing.

OK, Kathy, why don't you proceed? What a nice looking boy. Go ahead.

STATEMENT OF KATHY YANE, EUCLID, OH

Mrs. **YANE**. Good morning.

My name is Kathy Yane. I live in Euclid, OH, with my husband Jim and my three children.

Alex is our youngest, he's 7 years old, and has cerebral palsy. When Alex was born, we had no idea there was anything wrong. He had a normal birth, and he appeared to be normal, but when he was about 7 months old we noticed he wasn't developing the way other normal children develop. He wasn't rolling over, making cooing noises like babies do at that age.

After an extensive series of tests, a CAT [computerized axial tomography] scan showed there was brain damage. At 8 months of age, Alex began therapy at United Cerebral Palsy. At the same time, my husband and I began to look more closely into our health insurance. We compared our coverage to other policies available through my husband's job to see which policy would best cover Alex's medical and equipment needs. We chose an HMO policy, because it seemed to offer the most complete coverage for his condition.

Since Alex is extremely physically involved, he requires a lot of medical equipment. He needs an electric wheelchair to get around. He can't stand on his own, so he needs a supine stander to assist him. He has an activity chair, a stationary seating arrangement with a tray, which he uses to do his school work and to eat.

Since he cannot speak, he needs a special device called an All Talk, which is a picture board that says words or phrases when he touches a picture. All this equipment is very expensive.

We've been fortunate, the HMO covers 100 percent of this cost, but it's not always easy. When we went to purchase the wheelchair, HMO said they would only cover the cost of a regular wheelchair that you could find in a hospital. They said that an electric wheelchair was just a convenience. We couldn't believe it. As a matter of fact, to this day I can't imagine who is the convenience for.

Chairman OAKAR. Is that his wheelchair over there?

Mrs. YANE. Yes, that's his wheelchair there.

With Alex's level of muscle control, it's unlikely he'll ever be able to operate a regular wheelchair.

After we fought with HMO, they agreed to cover the cost of a regular wheelchair adapted for his use. Family Resources in Ohio agreed to cover 80 percent of the difference between the cost of the adapted wheelchair and the electric model.

There are other pieces of equipment Alex could use, but we keep it only to essentials. We want HMO to be there when we need it, and we're afraid if we ask for too much that they will cut back on what they will provide.

Just recently, the HMO announced that they were cutting back the amount of therapy they would cover a year to 20 sessions over 60 days. Up until now, Alex has been receiving weekly physical therapy. The weekly physical therapy is essential to keep his muscles loose. Frankly, without it, I don't know if he would be alive today; 20 or 30 years ago, children with severe cerebral palsy weren't given much of a chance.

His muscles are normally spastic, and without therapy he would also have spasms. He does get physical therapy at school, but we cannot rely on him getting it every week, and Alex will need therapy all of his life. It won't be long until he's out of school. What happens then?

We have the same problem with speech therapy. The HMO indicates they will only cover 10 sessions a year. This isn't going to help teach a nonverbal child to communicate.

We are left with three options, continue with HMO and pay the additional therapy out of our pocket, find a new policy, but most of them have higher copayments, or apply for assistance through the Bureau of Children With Medical Handicaps, a program we're not sure we qualify for because of our income.

Insurance companies and HMO's seem willing to provide physical therapy for accident victims and other short-term patients to help them recover functioning, and speech therapy for children who have trouble saying certain letters. They do not serve the long-term patient.

Alex's physical therapy and speech therapy needs are not going to go away. They are there for his lifetime. He will also have ongoing medical needs. I just hope that this cutback in our coverage for therapy isn't the beginning of further shrinking of coverage for care and equipment that Alex cannot live without.

Thank you.

Chairman **Oakar**. Well, thank you very much, Kathy, for your family—for you, and Jim, and your son, Alex, being here. I'm going to ask you some questions afterward, OK?

Mrs. **Yane**. OK.

Chairman **Oakar**. Our next witness is Ruth Reinking. Did I pronounce your name right? You are only—you are not even in the fastest growing age population yet. The fastest growing population are people over 85, you are only 81. So, one of the new kids on the block is going to testify.

Ruth, thank you very much for being here. You care for your husband, Carl, who is 87, is that right?

Mrs. **Reinking**. That's right.

Chairman **Oakar**. I think it's interesting to see the varieties of people because sometimes when we policymakers get together we sometimes see people who like to pit one age group against another, or one family group against another. The fact is, this is a national problem for varieties of people, it's not just one type of group. It's a variety of people, and this is a family problem for our country, and that's why we are really so grateful for the witnesses to demonstrate that.

And, you don't even represent all the people, different types of people who have different kinds of problems, but we are really grateful for you all being here.

Ruth, do you want to proceed? Just pull that as close as you can. Thank you.

STATEMENT OF RUTH REINKING, CLEVELAND, OH

Mrs. **Reinking**. My name is Ruth Reinking. I am 81, and I have been an insulin-dependent diabetic for 24 years.

Chairman **Oakar**. Just a little louder, Ruth.

Mrs. **Reinking**. OK.

Chairman **Oakar**. You just push that a little closer to you, OK?

Mrs. **Reinking**. I live right here in Cleveland with my husband, Carl, who is 87. Carl has hardening of the arteries of the brain. His symptoms seem to be a lot like Alzheimer's, but it's not. He is often depressed and very often hard to manage. It all started this past October. Carl was shaking, he couldn't talk, and as much as he tried he couldn't get up. I called the paramedics, and they said to take him to the hospital right away.

They kept him in the hospital as long as they could, and they had him see a psychiatrist because of his mental state.

Then, in November, he was transferred to a nursing home. The doctor said it was impossible for me to take care of him with my condition. I've also had a broken hip.

The home cost us $75 a day, and was fast depleting our savings account. In January, I brought Carl home for the weekend just for a visit. He seemed to like it and wanted to stay. I called the home and talked with them, and they thought it might be a good idea. On Tuesday, he was taken off their registration list.

Mostly, he's been doing pretty well, but it's been a little hard on me. I don't get as much rest as I should. I have to watch him all the time, since he really can't help himself and doesn't realize what he is doing. I have to help him dress, and I have to watch him constantly when he's in the bathroom.

He can walk, but he takes very small steps, so it takes him a long time to get from place to place. Up until last week, he was getting up three or four times a night, and often I was so tired during the day I couldn't see straight.

In addition to caring for Carl, I have the housework to do. There is a lot of laundry, meals, and vacuuming and dusting. All this is made harder because he doesn't like to be left alone. He likes me to be sitting next to him. So, I have to make sure that I am never out of sight for too long.

When Carl first came home. I tried to get someone to come in at night, but they don't offer that kind of service. Taking him out visiting or just going out seems to help him a lot, but I can no longer see well enough to drive, and it's hard getting people to help.

Our daughter lives in Chicago. She comes when she can, but she teaches school and has five children of her own. If she lived closer, it might be a different story. We'd have a lot more help.

If things keep on like they are right now, it's not too bad, but if Carl starts waking up in the night again, I don't know how long I could last, and sometimes he does get a little violent. We're keeping afloat right now financially, but it's not easy. Medicare doesn't cover the cost of psychiatrists very well either, and it costs about $250 a month for Carl's medications.

If Carl had to go back to the nursing home, it wouldn't take long to use up the rest of our savings. All we'd have left would be our home.

Carl was a farmer, then he worked during World War II making airplane parts in a plant in Elarium. After the war, he worked briefly with his brother in a gas station, and then with a cement contractor. It was hard work, but he liked it, it was outside.

In December, we'll have been married 54 years, and with a little help things would be a lot easier on me, and I wouldn't have to risk my health to take care of Carl at home, where I like to keep him.

Thank you.

Chairman OAKAR. Thank you very much.

The last witness on this panel is Ms. Chris Hall, who has a 3-year-old child, and I want to really thank you for being here, Chris. Your story is very much a part of an important record we need. Thank you.

STATEMENT OF CHRIS HALL, CLEVELAND HEIGHTS, OH

Ms. HALL. I need to preface my testimony by asking you all to be patient with me, because my speech is likely to disintegrate, but bear with.

It's wonderful to be able to talk again. For about 3 years, I couldn't talk at all. Let me start from the beginning, and the best way for me to tell you about myself briefly is to read the thoughts that I have asked to be put down, because putting thoughts into words spontaneously is very hard.

My name is Chris Hall, and, again, I ask your patience. You may think my speech sounds funny, but it's worth it to be able to—it's worth it to just be able to talk again.

For 20 years, I worked as a social worker, constructing evaluation instruments for social services and writing grants, and in 1981 I quit work to raise a family. I was married to a surgeon at the Cleveland Clinic, and I had two children. At the time of the problem, 1 was 16, and the other was 2. I played tennis daily, and I lived a normal middle-class existence.

All of that came to grinding halt in no time at all. Three years ago this past December, an aneurysm in my brain that no one knew about began to leak. I went to the hospital and was put in the intensive care unit for 3 weeks. An operation was performed to clip the aneurysm and stop the leak.

Although I have absolutely no memory of these events, or of any events of any kind for 9 months or 10 months after the aneurysm leaked, I have been told that during the surgery I had a tremendous stroke. The doctors expected me to die, and to make matters worse I had been divorced 2 months before all of this, and I was off my husband's insurance policy, and my own policy did not go into effect until January.

So, while all this was happening, I had no insurance. The medical bills alone were astronomical, totaling $60,000. Because of the stroke, I couldn't see, I couldn't talk, I couldn't think or understand speech, and I was paralyzed on my right side from my scalp to my big toe.

It was in this condition that I was released from the hospital only 2 weeks after the surgery, because I was without insurance. Since there was no money for a rehabilitation hospital or a nursing home or any other long-term care service, I was just sent home.

For 1 year, I lay in bed in a severe vegetative state, not moving, not seeing, not talking, and not barely thinking. I spent the rest of my life savings on women who dragged me out of bed to the bathroom and spoon fed me and turned me over in bed so I didn't get bedsores.

And, each one—each nurse aide would last a few weeks before they couldn't take it anymore, and quit, and then my friends would have to find someone else.

I spent over $5,000 on these nurse aides, and when the money ran out, the aides stopped coming. At that point, I relied on friends to help out when they could.

Bear in mind that I was a single parent, and my ex-husband didn't have any family support, except my son—my oldest son, Jacob, who was 17 at the time, and a junior in high school, bear in mind that in addition to the 17-year-old, I had a 2-year-old, and without my 17-year-old's help, I don't know how my youngest, who was only 2 years old would have survived.

My 17-year-old arranged for a sitter to come and pick up the 2-year-old every morning, and get him dressed and feed his breakfast and take him to their house and feed him all three meals and bathe him and bring him home ready to pop back into his crib in his pajamas.

My 17-year-old managed to coordinate all of the pieces, plus going to school at the time and do the shopping and cooking and he managed to do it all. He did this for about a year, until I could start to do things.

Slowly, my head started to clear a bit, and I began to improve. After about a year, I was able to see again. It took me about 3 years to be able to talk. I tried to get into a head injury program, but I couldn't afford to pay for it. I called and begged and pleaded. I had people call on my behalf, but they would not let me unless I signed a note saying that I was financially responsible, which I couldn't do. As it was, I had to sell my home to pay for the nurse aides.

Now, 3½ years after the surgery, I remain partially paralyzed on the right side, and have difficulty expressing myself, and a whole bunch of obvious disabilities.

The simplest test, imagine living life with using only one hand, and all of the myriad of tasks that it takes two hands to do. If you want to get an idea of what it's like some time, try putting a mitten over one hand and tie that arm to your side and use only one arm and one hand, even in an emergency.

Right now, I receive alimony so I manage financially, but that only lasts until 1990. I, frankly, don't know how I'll support myself after that. Finding jobs, even under the best of circumstances, is like pulling teeth.

Social workers without a funny looking eye, and the use of both arms and who can talk smoothly and who have no obvious disabilities are a dime a dozen. I tried finding a job through the Bureau of Vocational Rehabilitation, but they haven't turned up even job one.

I used to be qualified for lots of jobs in research, but I can't write, and that's a major drawback for those types of jobs. And, since I've never bought a lottery ticket, I can't wait for my ship to come in.

Since the incident, my health has been good. While I was incapacitated, though, lots of bills went unpaid. I was simply in no condition to address any kind of paperwork whatsoever, so the mail stacked up, and in the mail, obviously, were bills. Obviously, one of them was—the unpaid bills, was the premium for my Blue Cross policy, and it was canceled.

I was able to get it reinstated. Actually, some friends did the leg work, but I had to take a $2,500 deductible for the policy, and, in addition, the policy cost me about $1,200 a year. And, not being able to work, I, frankly, don't know how I'll be able to—how long I can sustain that, because for the policy even if it's of any use to me, it costs out of pocket $3,700 a year.

In addition, it's only use is in a horrendous emergency. It's of no value whatsoever for smaller—for normal health expenses and medications.

Through my whole experience, I was fortunate not to be entirely without resources. I am well educated and always got any job I ever wanted before. I've never been at the bottom of the economic ladder, but I guess the point is, you don't have to be to be financially devastated by the cost of an illness and not be able to afford the hospitals and doctors you need. I paid off $6,000 on the hospital bill, and the hospital forgave the rest. Had I not been married at one point to a surgeon there, I would still be paying off the bill, to the extent that I even have the resources, which I don't, but how many people can count on being married to a physician and having their bill forgiven?

I was raised in a medical household, and I've often wondered why other countries seem to be able to handle health care better than we can. After all my experiences, I am sensitive to the dilemma of people who can't afford the care they need. I was fortunate to get the care I did, but had to pass up care I needed to help my recovery because I simply ran out of money. I just don't think getting health care should depend on luck.

I could write a book, but it suffices to say, that's enough.

Chairman **Oakar**. I think maybe you should, you know.

Let me ask Patricia, you've had a lot of—you lost your insurance when you got divorced, is that right?

Ms. **Davis**. Yes, that's right.

Chairman **Oakar**. Initially, and then you remarried and your husband is not particularly well, and he's on and off as an employee, right?

Ms. **Davis**. Yes.

Chairman **Oakar**. And then you have children, some of whom have medical problems, and you have had medical problems.

Ms. **Davis**. Yes.

Chairman **Oakar**. And, you look pretty good to me, but I tell you, I know that cancer screening is very important, and I'm disappointed that you can't get that.

When you were under Medicaid, did Medicaid—when you were on welfare, and you obviously don't want to be on welfare or you wouldn't try to get these $4 an hour or whatever jobs you can get——

Ms. **Davis**. Right.

Chairman **Oakar** [continuing]. When you were on Medicaid, did Medicaid cover pretty much everything that had happened to you or your family?

Ms. **Davis**. Medicaid was there to pay the basic bills, but we were so limited, and you are limited on Medicaid when you are on the welfare system as to what doctor you can go to, what hospital program you can get into. It is just very limiting. You can't get the quality.

I had been experiencing excruciating pain, a lot of female problems while I was still on Medicaid back in 1983 and went to St. Joseph's Hospital in Lorraine and they found nothing wrong. They kept saying there is nothing wrong, there is nothing wrong.

And, when I did have the ovarian cancer, I also had a condition called adenomyosis, which is a thickening of the uterus, the lining, and it was to the point of maybe six times its normal size, the doctor said, on both sides. So, that had been building up over the years. But, you know, as I said, I was on Medicaid and I was told there was nothing wrong.

I was also in an auto accident while I was on Medicaid, went to St. Joseph's Hospital in Lorraine and had the Medicaid card, and my spine, a vertebra had been broken during the accident but they, of course, said there was no damage done to the spinal column. The spine was out of place, the vertebra was broken.

So, I don't feel that our Medicaid Program or welfare program is sufficient coverage for anyone, I really don't.

My middle daughter that is here today is 13 years old now. At that point in time——

Chairman **Oakar**. Where is she? Is she here in the audience?

Ms. **Davis**. She's in the audience. The oldest one that just had the emergency surgery isn't here. But, the 13-year-old has been very lucky, she's been very healthy, basically, over the years, she was shoveling snow at one time while we were on welfare to help out type of thing, and she lifted the shovel too much, tore the muscles in her side. We were literally turned away from an emergency medical service because we did not have proper insurance. They would not take Medicaid, period, so, therefore, I had to take her to another hospital emergency room.

Chairman **Oakar**. So, Medicaid didn't fit the bill either.

Ms. **Davis**. It's not the answer. No, it definitely is not.

Chairman **Oakar**. What's the answer for you? What would you like to see happen?

Ms. **Davis**. I feel we definitely have to have a national health bill. We have to have an Ohio health bill to start to be a model for the Nation, to show them how the Government can help take care of its own people.

We are just spending billions of dollars every year on the paperwork, on the bureaucratic nonsense that goes along with the different insurance companies, and that money could so much better be put into proper medical health care, adequate, quality health care, and we really have to—we are starting at a very grassroots level in Lorraine and Cuyahoga Counties, but we are people that care. We are just tiny little people, everyone of us on this panel are union people. Everyone that works and exists in this country, we all need adequate medical health care, and it shouldn't depend on what's in our pocketbook, it shouldn't depend on who we are married to, as a woman, as the head of a household with children. The Government has got to wake up and listen to its people. Every other nation in this world has proper medical care except for the United States.

Chairman **Oakar**. All right, thank you. Thank you, Pat.

One of the things I worked on quite a bit is the elder abuse issue, and, frankly, a lot of people abuse their older folks out of frustration but don't want to. They don't have a break from them.

Can you tell me a little about how your mother-in-law is treated in Canada, and what kind of things are covered that might be of help to you if our country had this kind of coverage?

Mrs. **Godessa**. Yes.

First of all, after she suffered for 12 years, she died last July. She was 82, and my father-in-law is 84. They've been married over 50 years, so, naturally, he did not want his wife in a nursing home, and he was able to keep her at home because 5 days a week there was someone there.

They have an organization called the Victorian Order of Nurses, and twice a week a nurse would come out and check her vital signs, and see that they were well taken care of, that they weren't having any problems. And, Mrs. Godessa, my mother-in-law, was their patient, but they also paid attention to Mr. Godessa. They checked his vital signs.

Three days a week she had a home health aide came to home for a minimum of 3 hours. They did—she would get my mother-in-law out of bed and bathe her, put her in a wheelchair, change the bedding, do the dishes, do the laundry, ask my father-in-law, go out, take a walk, you know, come back whenever you like, go to the post office. And, he was able, through this, to have some support system. He did not feel devastated. He did not feel alone. It didn't cost him 1 cent.

He had Meals on Wheels every day, and they provided such large lunches that he was able to have enough left over for dinner. He didn't have to worry about cooking, cleaning, absolutely nothing.

I love my country, I love the United States of America and would never dream of burning the flag, but I think this country needs to wake up to what Canada is doing for their people.

Chairman **OAKAR**. And, you had no access to any kind of congregate services——

Mrs. **GODESSA**. Absolutely not.

Chairman **OAKAR** [continuing]. To give you a break.

Mrs. **GODESSA**. I wish that there were more day care centers provided, where people—this lady, where she could take her husband in the morning and bring him home in the evening and give her a day. They have wonderful day care services, but there just aren't enough of them.

We need transportation to and from these day care services.

Chairman **OAKAR**. I visited a day care service in my district the other day, last Friday, and it cost, I think it was $20-some a day, which is relatively cheap. It's like $3 an hour or something like that, out in Middlebrook Heights; the Tri-City Center there has the service.

And, frankly, the people who take their parents and their loved ones there, and have a little break, and then come back, and they don't use it every day, but it just helps them, because most health providers are the families. But, the fact is that many people can't even afford that, and I thought that was such an excellent center; there are very few centers like that. In fact, we've heard from Alzheimer's groups—we had a full-blown hearing in our Aging Committee on this—and we're very close to doing the necessary research to find out, what triggers Alzheimer's in one's cells. Unfortunately, we've seen some increase in priorities in research in the military area and a decrease in priorities relative to health research, which I feel strongly should be reversed.

But, having said that, we have found nationally that very few nursing homes will take Alzheimer's patients——

Mrs. **GODESSA**. There's difficulty there.

Chairman **OAKAR** [continuing]. Let alone families, I mean, if you can afford the nursing home.

So, you really are sort of a living saint for what you are trying to do, and so is your family.

Mrs. **GODESSA**. I don't feel a saint. I just feel, that is my mother, and I think she would do the same for me.

And, by the way, my mother went to that Middlebrook Heights day care center, Southwest Adult Day Care Center, for 4 years. In fact, she received an award for having the most seniority, and she had a wonderful time when she was there. We could not afford to send her every day, but I was very thankful that that was there, but there aren't enough day care centers.

Chairman **Oakar**. Right. Well, that's an interesting contrast.

Kathy and Jim: Jim, what do you do, if you don't mind being part of our record?

Mr. **Yane**. No, it's all right. I'm a maintenance supervisor, and I work for TRW.

Chairman **Oakar**. You are with TRW.

You'd have to institutionalize your son, am I correct about this, in order to get Medicaid assistance for your child? Am I right about that?

Mrs. **Yane**. Yes.

Mr. **Yane**. Yes.

Chairman **Oakar**. And, you don't want to institutionalize your son, right?

Mr. **Yane**. No way.

Mrs. **Yane**. Uh-uh.

Chairman **Oakar**. No way.

Mr. **Yane**. I won't do it.

Chairman **Oakar**. You don't do it.

So, what should we be doing for you? What would help you, and what kind of coverage should we, as a country, be providing that isn't covered now? I assume you have private insurance, correct? You have a private plan?

Mr. **Yane**. We have an HMO.

Chairman **Oakar**. You have an HMO, that's right. You said that, and you saw the benefits go down.

Mr. **Yane**. That's the problem, is the problem with decreasing of the benefits, rather than just sustaining, and they just brought it up this year with the changes, and we don't know what's going to happen in the future.

Chairman **Oakar**. Now, I want to ask my legal counsel here, would it be cheaper for them to care for their child in their home, as opposed to institutionalizing that child?

Mr. **Howard**. No. Obviously, the cost of institutional care, particularly, for children with developmental disabilities, is not only very high individually, it's much higher than for an average nursing home. But, it is, incidentally, the fastest growing component of Medicaid costs, and the one that's probably causing the greatest growth in that budget.

Mrs. **Yane**. Can I make a comment?

Chairman **Oakar**. Sure.

Mrs. **Yane**. This is having to do with putting our child into an institution. No. 1, I did not want to have a baby so I could put him in an institution. I wanted to have a baby because I wanted to love my child, and have him at home with me. I didn't ask to have a son with cerebral palsy, it turned out that way.

And, I want in all my power to be able to keep him at home and nourish him as a family member of our family.

Chairman **Oakar**. Yes.

Mrs. **Yane**. Not to have someone else take care of him. And, I think that it's terrible for a parent to be put into a situation of someone saying, you can no longer take care of your child at home and you have to put him in an institution in order to survive. I think that's taking part of our rights away as individuals to be able to do that.

Chairman **Oakar**. That's right.

Mrs. **Yane**. I really feel he needs to be at home with the people who love him.

Chairman **Oakar**. And, you have how many other children?

Mrs. **Yane**. I have two children. I have a 12-year-old whose with us, and I have a 14-year-old son.

Chairman **Oakar**. And, I'll bet if I asked your 12-year-old what he would want——

Mrs. **Yane**. What she would want?

Chairman **Oakar** [continuing]. Or, she, oh, I'm sorry. Hi. Why don't I ask you that? Come on up here. Will you come up here for a minute? Sure. We want to show this is a family issue. You are going to help us out. Your dad is going to give up his seat.

Mr. **Yane**. I don't do that all the time.

Chairman **Oakar**. I know. Could you tell us your first name, honey?

Jenny Yane. Jenny.

Chairman **Oakar**. Jenny. Now, would you prefer to have your brother at home?

Jenny Yane. Yeah.

Chairman **Oakar**. Yeah. Do you help your mom and dad at home?

Jenny Yane. Yes, I do.

Chairman **Oakar**. All right. Well, that's very helpful to us, Jenny. Thank you.

Mr. **Howard**. Could I just ask Mr. Yane one quick question. If you had a chance for a new job with a different employer that was a big improvement in your responsibilities and your salary, would you be able to take it and get health insurance coverage through your new employer?

Mr. **Yane**. I really don't know. I don't know the answer to that. Probably not, I would have to say it would be very difficult, depending on going back to the small business issue, depending on the size.

The company I work for, we have 1,200 employees, and my insurance is very easy to get.

Mr. **Howard**. Thank you.

Chairman **Oakar**. So, in other words, you work for a company that provides health insurance, right?

Mr. **Yane**. A very large company, yes.

Chairman **Oakar**. TRW provides—they provide 100 percent—they pay for 100 percent of your coverage? They do. But, the fact is that most health insurance policies, even if you have one, don't cover the needs of this family. So, that's another whole issue that I think we have to get into, don't we?

Mrs. Reinking, you used up—did you have your husband in a nursing home for a while?

Mrs. **Reinking**. Yes. He was there from early in November to January.

Chairman **Oakar**. And, you used up a lot of your savings, didn't you?

Mrs. **Reinking**. Yes, that takes a lot, that's for sure; $75 a day goes pretty fast.

Chairman **Oakar**. Boy, I'll tell you, it must.

Mrs. **Reinking**. Plus, medication, even in the nursing home you paid your medication.

Chairman **Oakar**. And, you're the sole provider for your husband pretty much.

Mrs. **Reinking**. Yes.

Chairman **Oakar**. Do you have any other help?

Mrs. **Reinking**. Well, I have some good neighbors that come in and help, take me shopping for groceries when I need things, and I have a sister-in-law, my husband's sister, but she isn't too well. So, I don't—she does help a little bit, but not too much.

But, at home, actually, there is no other help.

Chairman **Oakar**. And, you just do all the providing. Now, isn't that phenomenal? You do all the providing yourself.

Mrs. **Reinking**. Yes.

Chairman **Oakar**. What would help you? Give me a couple examples of what would help you in your health delivery? You know, keeping your husband at home, what kinds of services would help you that would make you a little less tired and maybe able to even do more?

Mrs. **Reinking**. Well, someone could come in and take care of him at night, that would be a big help. The other things, I think, so far I'm able to do.

Chairman **Oakar**. Why at night?

Mrs. **Reinking**. Well, with his condition, he doesn't know when he needs to go to the bathroom, and sometimes he gets up and he wakes me up, and he has to go to the bathroom. Well then, I've got to go along, and then it seems to be a long process, sometimes one-half an hour.

Chairman **Oakar**. And, you don't get the proper rest, do you?

Mrs. **Reinking**. And, you don't get much rest that way when you get up two or three times a night, and you spend—well, it adds up to a couple of hours in the bathroom.

Chairman **Oakar**. Do you ever get a chance to go out at all socially, or——

Mrs. **Reinking**. Not too much, but——

Chairman **Oakar**. Do you ever have anybody who will watch your husband?

Mrs. **Reinking**. I haven't so far. Whenever I've gone out, we've taken him along.

Chairman **Oakar**. You take him with you?

Mrs. **Reinking**. Yes. We've had some relatives that were able to take us out a few times.

Chairman **Oakar**. How often do you get out?

Mrs. **Reinking**. Well, this last few weeks, it's been quite a bit. We've been out every Sunday. And, we were out last night for dinner, which was a wonder. His sister from Wisconsin was here, and they left this morning. They didn't stay at my house, they stayed at his sister that lives in Parma.

Chairman **Oakar**. That's pretty rare that you——

Mrs. **Reinking**. Yes, it's rare——

Chairman **Oakar** [continuing]. Are able to do that.

Mrs. **Reinking** [continuing]. That we get to go out like that.

Chairman **Oakar**. And, if you had a little break for your own time, would that be helpful to you?

Mrs. Reinking. Yes, it would.

Chairman Oakar. Boy, I don't know how you do it. I mean, isn't that amazing? It's just tremendous.

Let me ask you, Chris, if I can call you Chris, what we've seen today is a very common phenomenon, women who are head of the household. You are divorced, and then to top it off you became disabled.

Ms. Hall. Uh-huh.

Chairman Oakar. And, are you a social worker by profession?

Ms. Hall. Uh-huh. I have a master's in social work.

Chairman Oakar. You have a master's in social work.

Ms. Hall. Yes.

Chairman Oakar. Another undervalued profession.

Ms. Hall. Yes.

Chairman Oakar. But, if you could, you would—did you—you were getting some kind of support from your husband, I gather, is that correct, for your children?

Ms. Hall. Am I currently? Your question is hard to answer, because to be very honest, when I was in the hospital my husband discontinued illegally support, and he said: "Well, you are in the hospital, you don't need money."

Chairman Oakar. So, you didn't have support while you were incapacitated in the hospital.

Ms. Hall. No.

Chairman Oakar. What about your kids? I mean, who took care of your children?

Ms. Hall. Well, the older one took care of the younger one.

Chairman Oakar. Your older child took care of your younger child.

Ms. Hall. Uh-huh. When he was going to high school, he arranged for the baby sitter that my 2-year-old had gone to, to allow me to play my daily tennis. She agreed to come, drive over and wake up my 2-year-old, and get him dressed, and take him to her house and feed him, and keep him all day. Without her and what my oldest son managed to do, and to do everything else that needed to be done, plus going to high school, I don't know how we would have done anything.

As it was——

Chairman Oakar. What great kids you must have?

Ms. Hall. I do. And, I suppose every mother thinks their kids are great.

Chairman Oakar. Well, let me ask you this. My staff told me that you really wanted to testify today because you feel very strongly about this issue.

Ms. Hall. I do. You know, I came close to ranting and raving over the telephone about the very fact that, I mean, you know, statistically between—excuse me——

Chairman Oakar. That's all right.

Ms. Hall [continuing]. I don't have the statistics in hand, but in all probability Americans are much more likely to grow up in single-parent households than with—yeah, and that seems to be an increasing problem. What do we have for a divorce rate?

Chairman Oakar. One out of two.

Ms. **Hall**. It's something like 60 percent of first marriages, and it escalates with each marriage. I mean, what kind of dilemma are we creating for our single parent, for women with children? And then, not only do we ask them to raise children by themselves and work, but we run the risk of—they, as much as I—run the risk of having suddenly a disability, and having to contend with huge medical problems and expense, and raising children, and all of the pieces.

If I could express myself better——

Chairman **Oakar**. I think you are doing terrific. You walk circles around most of us.

Go ahead.

Ms. **Hall**. No. Ask me a question.

Chairman **Oakar**. Well, you know what it is, is that we have—if my memory serves me correctly—about 26 million women who are part of a two-parent couple——

Ms. **Hall**. Part of what?

Chairman **Oakar** [continuing]. And 11 million women who are head of their own households, 1 out of 2 couples are probably in a divorce in this country, and the demographics are a lot different than when my parents were younger, and we have not faced that reality.

And then, if you become incapacitated, you even though you are very well educated and obviously able, would have been able to manage. It's really a very difficult thing.

That's why I was struck with your testimony, Ms. Davis, when you talked about making $4 an hour. We just tried to get a minimum wage bill passed for $4.55 an hour, and it was vetoed. There's no health insurance associated with those kinds of jobs. I mean, I think we are really way off in our priorities.

Ms. **Hall**. Absolutely.

Chairman **Oakar**. But, anyway, I think this panel took a lot of courage, God bless you all, and believe me when I tell you, you just have strengthened my will to do something about this.

So, I want to thank you all very much. I hope you'll keep in touch with us.

OK. We have our last panel, but not our least panel. Dr. Robert Binstock, who is at Case Western Reserve University, Department on Aging, Health, and Society. Would you come up, doctor? Dr. Glynis Laing, I believe it is, who is a Ph.D. in nursing, director at Lutheran Hospice Community Program; Dr. Kenneth Frisof, director of the Northeast Ohio Coalition for Health Insurance; and, we have John Gillespie, who is vice president of planning and marketing at the MetroHealth Center, Greater Cleveland Hospital Association; Mr. Werner Lange, who is the community specialist for the Interchurch Council.

Can we have order? We have some very important testimony to finish, and we don't want you to think that the last panel is not equally as important, because these groups are doing some very interesting work for us, and it's important for us to hear you.

Mr. Werner Lange, who is community specialist for the Interchurch Council, Greater Cleveland. Where is one of my favorite people, Dr. Castele, is he here? There he is. The infamous Dr. Castele is on television all the time, but he's with Lutheran Hospital. And Dr. Ed Chardnock of the Ohio State Medical Association.

Why don't I stop there, and then we'll have the rest. And, Dr. Chardnock, is he here as well? Do you want to come up with them? Do we have another chair over there? There's one right behind Dr. Castele. If we could just pull that over, we'll get you all in here, because I know you are going to have a broadcast pretty soon, I know you've got to tape that, doctor.

OK. We're going to have four other panelists. I apologize for the length, but, you know this is so important that we get a cross section of viewpoints. There's not an easy solution to this problem, there really isn't in my judgment. I think we have to really get a combination of ideas here. That's why we are so proud to have everybody here.

Let's see, Henry Manning was here, I want to make that clear, who is a very fine president at Metro General Hospital. He, unfortunately, had to leave, but we will put Henry's statement in the record.

So, let me stop right here, and, Dr. Binstock, if you would go ahead. I appreciate your being here. Thank you.

STATEMENT OF DR. ROBERT BINSTOCK, CASE WESTERN RESERVE UNIVERSITY, DEPARTMENT ON AGING, HEALTH, AND SOCIETY

Dr. Binstock. Thank you, Congresswoman Oakar, for the honor of being invited to share a few thoughts with you and the Commission this morning.

I must say, I had most of what I wanted to say committed to memory, and after listening to the last panel it's just about totally disintegrated. When you get down to the reality of human life a few abstract thoughts just don't compare.

Briefly, what I want to talk with you about is the eloquent and humanitarian plea that's been made in the last several years, led by the late Congressman Pepper, for expanding long-term care public insurance to try to make care affordable and accessible to everyone.

I think there are some fundamental issues regarding this very desirable goal, which most Americans would agree to, which have been bundled up. And what I want to do is to take one or two of them in a couple of minutes and unbundle them, with no easy solutions but a couple of opinions.

First, should long-term care insurance be expanded beyond its present coverage? By stating the question that way, I want to highlight that Medicaid is public long-term care insurance for poor people who go to nursing homes. I think a high priority from my vantage point would be to get Medicaid coverage expanded to the full range of services that are necessary for a person to remain viably at home in long-term care, so that we can give poor or medically indigent patients of all ages a genuine choice between home care and a nursing home. That's so the dice aren't loaded in favor of a nursing home or institutionalization by virtue of public policy.

Second, and this is really my last unbundle of bundles here——

Chairman OAKAR. And, by the way, doctor, I'm going to put your entire statement for our record.

Dr. BINSTOCK. Thank you.

Chairman OAKAR. Thank you.

Dr. BINSTOCK. Second, should public long-term care insurance be expanded beyond persons eligible for Medicaid? Should there be universal insurance to protect all Americans from spending down their income and assets on long-term care? I think that's a tough question to discuss, and if the answer is yes, I would hope that the Commission bases it on a thorough examination of some of the fundamental issues which haven't had an airing.

Now, certainly one fundamental issue that has been aired is the traditional argument that we do not like to see spouses impoverished by the institutionalization of the other spouse. As you know, the Medicare Catastrophic Coverage Act provides some protection on that. The principle is firmly established. I think a lot of us would agree it could probably be strengthened in terms of levels of protection of assets and incomes. Just how much strengthening is a technical matter we can leave behind for the moment.

An implicit argument for expanding long-term care public insurance seems to be that Americans have a genuine ideological and psychological abhorrence, a hate, for using up their assets on their own long-term health care. I think the Commission really needs to examine how deep and widespread that discomfort is. It needs to ask, why shouldn't Americans, especially older Americans, be spending their assets on their health care as opposed to other goods and services, if they can afford it?

And, I hope the answers come back that there are some reasons why they shouldn't, but I think for the political debate it has to be investigated, especially compared as a priority to insuring the 37 million so-called uninsured more generally for health care, which is a competing and very urgent matter.

And, finally, less implicit, sometimes openly stated, is the desire of many middle class and wealthy Americans to preserve their assets for their children and their grandchildren, rather than deplete their resources on long-term care.

This is an understandable desire, but I think we have to ask, and the Commission ask on behalf of all of us, is taxing some Americans to preserve the estates of others a desirable and viable goal of public policy? Would it be equitable and feasible to levy such taxes on a sliding scale based on income, or based on assets, or both?

Well, you, Congresswoman Oakar, and your fellow Commissioners, will need to answer such questions. I don't have to, fortunately, but you have the unenviable task of doing that, as well as choosing the payroll tax, the user tax, and other mechanisms for dealing with this.

I wish you good luck with this, and we are all looking forward to your recommendations to getting us all protected.

Thank you.

[The prepared statement of Dr. Binstock follows:]

"Issues in the Expansion of Public Long-Term Care Insurance"

Testimony before the

UNITED STATES BIPARTISAN COMMISSION
ON
COMPREHENSIVE HEALTH CARE

presented by

Robert H. Binstock, Ph.D.
Henry R. Luce Professor of Aging, Health, and Society
School of Medicine
Case Western Reserve University
Cleveland, Ohio 44106

Q— what if insurance plans were partly funded thru estate tax?

at a hearing
on July 6, 1989,
in Cleveland, Ohio

Thank you Congresswoman Oakar for the honor of being invited to share my views with the Commission today.

In the last several years we have heard many eloquent and humanitarian pleas, led by the late Congressman Claude Pepper, for a comprehensive range of high quality long-term care services -- both outside and inside nursing homes -- readily accessible to chronically ill and disabled persons of all ages. Most Americans would agree that this is a highly desirable national goal.

But there are some fundamental issues regarding this goal that seem to have been swept up in a bundle, and have hardly received public discussion. In the few minutes that I have available with you, I would like to briefly "unbundle" some of them in outline form, and express a few opinions.

First, should public long-term care insurance be expanded beyond its present coverage? Any serious consideration of this issue has to start with the fact that we already have public long-term care insurance in the form of Medicaid. That is, any person who becomes unable to pay for long-term care becomes eligible to have Medicaid pay. However, the home health benefits reimbursed by Medicaid do not ordinarily include the full range of services often necessary in a home care setting. Consequently, the medically indigent rarely have a choice between home care and a nursing home. In most states, Medicaid patients who need a full range of supportive services must enter a nursing home to have public insurance for adequate long-term care.

If public long-term care insurance is to be expanded, a first, pragmatic step would be to broaden Medicaid coverage to the full range of supportive home care services. This would give poor patients a genuine choice, as opposed to the current policies that "load the dice" in favor of institutionalization.

Second, should public long-term care insurance be expanded beyond persons eligible for Medicaid? Should there be universal insurance to protect all Americans from "spending down" their income and assets on long-term care? As a recent Brookings Institution study of the elderly population indicated, even under the most favorable conditions private long-term care insurance will ultimately provide adequate coverage for only 30 percent of that group (Rivlin and Wiener, 1988).

One traditional argument in favor of expansion has been that it is needed to protect the income and assets of the non-institutionalized spouse of a patient. Yet, as you know, the Medicare Catastrophic Coverage Act of 1988 now protects the spouse from impoverishment. Perhaps the protection should be increased, but the principle is firmly in place and stands as a strong counter argument.

A second argument has been that a patient should not have to spend down his or her assets, recover, and then leave the nursing home in an impoverished condition. But this is a weak argument since such situations very rarely occur for long-term care patients.

An implicit argument for expansion seems to be that Americans have a genuine ideological and psychological abhorrence to using up their assets on their own health care. How deep and widespread is this discomfort? And how does the priority of eliminating it compare with the priority of expanding public insurance to the 37 million who are entirely uninsured for their health care?

Less implicit, sometimes openly stated, is the desire of many middle-class and wealthier Americans to preserve their estates for their children and grandchildren, rather than deplete their resources on long-term care. This is an understandable desire. But is taxing some Americans to preserve the estates of others a desirable and viable goal of public policy? If so, would it be equitable and feasible to levy such taxes on a sliding scale based on income and assets?

You, Congresswoman Oakar, and your fellow Commissioners, will be answering such questions this fall, in one way or another. You will also have the unenviable task of choosing among the payroll tax, user taxes, general revenues, or other mechanisms to finance any expansion you recommend in public long-term care insurance. I appreciate this opportunity to underscore some of the fundamental issues embodied in the decisions you will make, and to offer some selected views on them.

REFERENCE

Rivlin, A.M., and Wiener, J.M. (1988) Caring for the disabled elderly: who will pay? Washington, D.C.: The Brookings Institution.

Chairman OAKAR. Thank you very much, doctor.

Dr. Laing, am I pronouncing your name correctly?

STATEMENT OF DR. GLYNIS LAING, R.N., Ph.D., DIRECTOR, COMMUNITY HOSPICE PROGRAM, LUTHERAN MEDICAL CENTER

Dr. LAING. Yes.

OK. I'm Dr. Glynis Laing. I'm director of the Hospice Program at Lutheran Medical in Cleveland.

Hospice, in a nutshell, is a program that provides palliative and supportive services in both the—well, totally, the physical, the psychological, social, and spiritual care of dying patients and their families. Services are provided both in home and in an inpatient setting.

Hospices receive a fixed daily rate for services provided to Medicare beneficiaries. These rates have not changed since Congress enacted a modest increase in 1986.

As structured, the reimbursement rates discourage admission of expensive patients, reducing the cost effectiveness of hospice care.

To elect hospice care, beneficiaries must waive other covered services related to the terminal illness. New respite care and home intravenous drug benefits were added to Medicare by the Medicare Catastrophic Coverage Act of 1988.

Hospice patients should be allowed to receive these new benefits if ordered by the patient's physician and the hospice interdisciplinary team.

The Senate Finance Committee and the House Ways and Means Committee will consider proposals to update Medicare hospice rates for inflation since 1986 and index future rates, create an outlier policy to reimburse extraordinary costs, and to clarify that home respite and home intravenous drug therapy are not among the Medicare benefits waived by terminally ill beneficiaries who elect hospice care.

In 1986, the Congress added hospice care as an optional Medicaid benefit. States are required to provide the same program design and pay the reimbursement rates as Medicare.

Differences between Medicaid and Medicare Programs has made this mirror image requirement inappropriate in some respects. For example, some States provide attendant care for Medicaid beneficiaries to enable them to remain at home. This is not a Medicare covered service, and the hospice reimbursement rates were not meant to cover the costs of such care.

Federal officials, however, are requiring States to include attendant care among the services waived by Medicaid to hospice patients. Some States reportedly have attempted to withhold food stamps, Meals on Wheels, and other benefits from hospice patients as well.

Tying the reimbursement rates to Medicare levels has simplified ratesetting and has protected hospices from being grossly underpaid for services. However, some States, notably New York, would be willing to pay additional amounts if allowed under Federal law.

The Senate Finance Committee and the House Energy and Commerce Committee will consider proposals to clarify that only those Medicaid services covered under Medicare must be waived by the hospice patient and make the Medicare reimbursement rates the floor and not the ceiling on Medicaid hospice payments.

Small businesses are currently being squeezed in the health care cost crunch by their health benefits plan, and, consequently, employers have begun to view the hospice option as an enhancement of their existing medical plan, which at the same time offers potential cost savings.

There is a growing trend toward a separately defined hospice benefit or contract rider, which offers a comprehensive range of services. This introduces the element of coordination, since most hospice services would be reimbursed under a single benefit. This would permit tracking the hospice experience accurately to determine cost savings.

Yesterday, it came to my attention that, apparently, when large businesses choose to elect a hospice benefit on their insurance plan, that they receive a discount for their premium because they are choosing to go with a cost savings way to provide care. On the other hand, small businesses, when they choose to add a hospice benefit to their insurance policy, are charged at a higher rate, because they are uninformed consumers and aren't aware that this is a cost savings way to do it. So, it seems the hospice group, as a whole, has some education to do among the small business community that this is a cost savings plan, rather than a more expensive plan.

Thank you.

[The prepared statement of Dr. Laing follows:]

U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

PUBLIC HEARING
JULY 6, 1989
CLEVELAND, OHIO

Oral Testimony by Glynis Laing, R.N., Ph.D., Director of Community Hospice Program, Lutheran Medical Center, Cleveland, Ohio.

A hospice is a program of palliative and supportive services which provides physical, psychological, social, and spiritual care for dying persons and their families. Services are available in both the home and an inpatient setting.

Hospices receive fixed daily rates for services provided to Medicare beneficiaries. These rates have not changed since Congress enacted a modest increase in 1986. As structured, the reimbursement rates discourage admission of expensive patients, reducing the cost-effectiveness of hospice care.

To elect hospice care, beneficiaries must waive other covered services related to the terminal illness. New respite care and home intravenous drug benefits were added to Medicare by the Medicare Catastrophic Coverage Act of 1988. Hospice patients should be allowed to receive these new benefits, if ordered by the patient's physician and the hospice interdisciplinary team.

The Senate Finance Committee and the House Ways and Means Committee will consider proposals to:

* Update Medicare hospice rates for inflation since 1986 and index future rates;

* Create an outlier policy to reimburse extraordinary costs; and

* Clarify that home respite care and home intravenous drug therapy are

not among the Medicare benefits waived by terminally ill beneficiaries who elect hospice care.

In 1986, the Congress added hospice care as an optional Medicaid benefit. States are required to provide the same program design and pay the same reimbursement rates as Medicare. Differences between the Medicaid and Medicare programs have made this mirror image requirement inappropriate in some respects. For example, some states provide attendant care to Medicaid beneficiaries to enable them to remain at home. This is not a Medicare-covered service, and the hospice reimbursement rates are not meant to cover the costs of such care. Federal officials, however, are requiring states to include attendant care among the services waived by Medicaid hospice patients. Some states reportedly have attempted to withhold food stamps, meals-on-wheels, and other benefits from hospice patients as well.

Tying the reimbursement rates to Medicare levels has simplified rate-setting and has protected hospices from grossly inadequate payment levels. However, some states (notably New York) would be willing to pay additional amounts if allowed under federal law.

The Senate Finance Committee and the House Energy and Commerce Committee will consider proposals to:

* Clarify that only those Medicaid services covered under Medicare must be waived by the hospice patient and

* Make the Medicare reimbursement rates the "floor" but not the "ceiling" on Medicaid hospice payments.

Small businesses are currently being squeezed in the health care cost crunch by their health benefits plans. Consequently, employers have begun to view the hospice option as an enhancement to their existing medical plan which at the same time offers the potential for cost savings.

There is a growing trend toward a separately defined hospice benefit or contract rider which offers a comprehensive range of services. This introduces the element of coordination since most hospice services would be reimbursed under a single benefit. This would permit tracking the hospice experience to accurately determine cost-savings.

Thank you for your support of the hospice alternative for the terminally ill in our area. We provide services of an interdisciplinary team including physician, nursing, social work, counseling and volunteer services to patients and their families, including bereavement services. We rely on volunteers for a significant portion of our services, but we must also depend on adequate third-party reimbursement. The Congress of the United States has created and nurtured Medicare and Medicaid benefits which have allowed thousands of terminally ill Americans to die in their own homes, as free from physical and emotional pain as possible. We who provide this care thank you for making it possible.

Chairman **Oakar**. Thank you very much.

Dr. Castele, and you are also with——

Dr. **Castele**. Dr. Chardnock.

Chairman **Oakar** [continuing]. Dr. Chardnock, yes, from the Ohio State Medical Association.

Dr. **Castele**. Thank you, Mary Rose.

My voice is not too strong today. I'm recovering from walking pneumonia.

Chairman **Oakar**. Are you really?

Dr. **Castele**. I'm glad I have my doctor here, because I feel like I'm walking backward with it right now. I'm not in the contagious stage.

Chairman **Oakar**. Didn't I see you on television the other night?

Dr. **Castele**. Well, a lot of that's taped beforehand.

Chairman **Oakar**. Oh, I see. OK.

Dr. **Castele**. But, I do appreciate the chance of being here today to discuss things with the Commission.

Chairman **Oakar**. Well, we are glad to have you, doctor.

Dr. **Castele**. I was very impressed with your prior panel, and they really had to say an awful lot that I think all of us physicians in Ohio and across the Nation really are concerned about. These are the people that we see every day. These are the patients that we take care of, and we are just as concerned about their health insurance and their availability of getting care as they are. We want to do everything we can to help them.

I have submitted a formal report. I'll just sort of paraphrase it, if you don't mind.

Chairman **Oakar**. We'll put the entire report in our record, doctor. Thank you.

STATEMENT OF DR. THEODORE CASTELE, OHIO STATE MEDICAL ASSOCIATION

Dr. **Castele**. Thank you.

My name is Theodore Castele, and although I'm here representing organized medicine, I'm also representing all of the physicians of Ohio and across the country, and all of the patients, the patients in the audience, and the patients throughout Ohio that we see and love and care for as much as we are able to.

My wife and I just lost both of our parents in the last 7 months. We've gone through some of the very same things the prior panel talked about. I do understand and am sympathetic, and I had more than one tear in my eye this morning as I heard their stories. So, we do have an appreciation of what it takes to take care of not only the patients but the families that go along with it.

Mary Rose, we are concerned about a number of things. First of all, the Bush administration, along with the Reagan administration prior to it, claims they are going to increase Federal revenues by increasing the gross national product, rather than by increasing the tax rate. That's a laudable goal, and I hope they can do that.

However, what we're finding out is what's really happening is they are trying to cut the budget by cutting the Medicare benefits to the Medicare beneficiaries, and that is simply not right. Those people deserve that care, they need that care, and we are opposed to all those cuts.

Chairman **Oakar**. Good for you. I am, too.

Dr. **Castele**. One of the key proposals that just came out in the last couple of weeks is called a proposal of expenditure targets. They want to limit the amount of services that we doctors can deliver to our patients. Furthermore, they want us to do the rationing. They are not even willing to do the rationing themselves, they want us to decide who is going to get care, and who we say "no" to. Are we going to say "no" to the lady who had the intracerebral aneurysm that we talked to a few minutes ago? Or are we going to say "no" to the small child that needed a CAT scan or an MRI [magnetic resonance imaging] scan to detect a brain abnormality? Are we going to say "no" to the 81-year-old wife who is caring for her 87-year-old husband? We can't say "no". We don't want those cuts made. We don't want to have to ration health care to our citizens. We beg you to not let Congress do that. Do not allow them to have expenditure targets. We say, as in the movie, "ET, go home," we don't want ET's.

Second, I heard what the people said about the Canadian system today, and I know there are good things about the Canadian system, but let me please tell you some of the shortcomings of the Canadian system.

First of all, they have ET's, they have expenditure targets. Their hospitals routinely will close beds when they see their budget about to be unbalanced. How would you like to close beds in this country if we had an influenza epidemic, or if you read the paper this morning, we're having a scarlet fever epidemic? How would you like to close beds under those circumstances? How would you like to have waits of 8 to 10 months to have cardiac surgery, and people with scarlet fever are the ones who are going to get heart disease, and who, ultimately, are going to need cardiac surgery.

How would you like to have the high technology of the magnetic resonance imaging machines not be available? It's wonderful, the greatest diagnostic invention since the x ray was discovered in the 1890's. We have one of these machines in this country for every quarter of a million people, in Canada they have one machine available for every 2 million people. We have eight times the ability to deliver magnetic resonance imaging service to our people than the Canadians do per capita. Is that the kind of system you want?

Do you want to have to wait for treatment? Their newspapers now are saying that people are dying in Canada because they cannot get surgery because they have such long waits. They cannot get orthopedic consultations. They cannot get their cataracts removed. They cannot get their hips fixed. Now, that's the downside of Canada. Do you want to have that? I know, Mary Rose, you don't want to have it. I know you don't want to have this cut in Medicare.

Chairman **Oakar**. I want to have it all.

Dr. **Castele**. Right. We all do. And, we want to give it.

Chairman **Oakar**. You know what, I'm glad you are talking a little about the downside, because I remember a couple of years ago when we had planeloads of people from Germany, West Germany, come to our area, our health delivery system, for open heart surgery. They had been on a waiting list for many, many months. And, they don't accommodate that type of surgery to the extent that we do here.

So, there are downsides to those plans. That's why when we study them, we have to take a look at those downsides, but there's some good things too, and I think you've heard some of the things today.

Dr. CASTELE. Yes, there are good things, and we ought to be able to try to take some of the good things, but let's also look at some of the bad things and not take those.

Chairman OAKAR. Sure.

Dr. CASTELE. We do have a positive program. We believe in Congressman Gradison's program of what he calls practice parameters. These are guidelines established by doctors, and by the medical profession, guidelines as to how medicine should be practiced properly, and we believe in following those guidelines and trying to squeeze out overutilization. If there is $150 billion of excess care, and I don't think there really is that much, but whatever the number is, we believe in following those guidelines.

We believe that research projects, as John Morley talked about earlier, is a very good idea, but let's not just automatically say you have to have all these other things he talked about without doing the research first? You might find out with national health insurance you are going to have longer waits, less service, and your taxes are going to be a lot higher, and not lower, and you are going to have worse medical care, not better care.

Now, I just sort of highlighted what I had to say. I'd like to conclude by saying, if my voice will hold out, our poor, our disabled, our elderly, and every single American, deserves to have excellent care. We ask you not to begin to dismantle a system which can bring high quality care for the sake of short-range monetary savings.

The system can always be improved, and we admit that, and we stand ready to help you in designing a better system, but, please, our patients deserve better than to have their health care budget cut out from beneath them. We're talking about the care, not only to our elderly, but the care also to all of you, to your children, to your grandchildren, and to my soon to be nine grandchildren.

Thank you very much, and here's Dr. Chardnock to talk for the emergency physicians.

[The prepared statement of Dr. Castele follows:]

TESTIMONY BEFORE THE

UNITED STATES BIPARTISAN COMMISSION ON

COMPREHENSIVE HEALTH CARE

JULY 6, 1989

PRESENTED BY:

THEODORE J. CASTELE, M.D.

MEMBERS OF THE COMMITTEE, MY NAME IS THEODORE J. CASTELE, M.D., AND ALTHOUGH I AM HERE TODAY REPRESENTING THE AMERICAN MEDICAL ASSOCIATION, THE OHIO STATE MEDICAL ASSOCIATION AND THE ACADEMY OF MEDICINE OF CLEVELAND, I AM REALLY SPEAKING FOR THE PRIVATE PRACTICING PHYSICIANS THROUGHOUT OHIO. I ALSO AM REPRESENTING THE PEOPLE OF OUR STATE, OUR PATIENTS WHOM WE SEE AND TREAT EVERY DAY, ESPECIALLY THE POOR AND THE ELDERLY. WITH ME IS ED CHARDNOCK, M.D., AN EMERGENCY PHYSICIAN WHO WILL BE FOCUSSING ON THE PROBLEMS FACING OUR EMERGENCY UNITS.

I WOULD LIKE TO THANK THE COMMISSION AND MY CONGRESSWOMAN, MARY ROSE OAKAR, FOR INVITING ME TO TESTIFY. I CONGRATULATE YOU FOR YOUR NOBLE EFFORT IN WORKING TO SOLVE ONE OF THE MOST PRESSING ISSUES BEFORE OUR COUNTRY. WE ARE ALL ON YOUR SIDE AND WISH YOU GODSPEED. WE MAY DIFFER IN OUR APPROACHES TO THE SOLUTION BUT WE CERTAINLY ALL AGREE WITH THE GOAL, TO BRING THE BEST POSSIBLE HEALTH CARE TO OUR CITIZENS.

WE MUST FIND A WAY TO GIVE HIGH QUALITY MEDICAL CARE TO OUR ELDERLY, AND ESPECIALLY WE MUST FIND A SOLUTION TO THE ISSUE OF LONG-TERM CARE. MY WIFE AND I LOST OUR OWN MOTHERS IN THE PAST SEVEN MONTHS AND HAD THE PROBLEMS OF THEIR CARE AND OTHERS IN SIMILAR CIRCUMSTANCES AMPLY BROUGHT BEFORE US.

IT WOULD BE A MISTAKE HOWEVER TO SOLVE ONE PROBLEM BY CREATING MUCH WORSE PROBLEMS. I KNOW OUR ADMINISTRATION IS TRYING TO RAISE REVENUE BY RAISING OUR GROSS NATIONAL PRODUCT RATHER THAN BY RAISING THE TAX RATE, WHICH IS A LAUDABLE GOAL, BUT SOME OF THE PROPOSALS WE ARE SEEING ARE 'ROUND-ABOUT WAYS OF SIMPLY CUTTING EXPENSES TO THE DETRIMENT OF OUR ELDERLY PEOPLE BY REDUCING THE ALLOCATIONS TO MEDICARE RECIPIENTS.

THERE ARE SEVERAL PROPOSALS BEFORE CONGRESS THAT WOULD LIMIT THE AMOUNT OF CARE MEDICARE PATIENTS CAN RECEIVE. ONE OF THESE IS A PLAN TO LIMIT THE ALLOCATION TO FUND DOCTORS' SERVICES TO MEDICARE PATIENTS, IT IS REFERRED TO AS "EXPENDITURE TARGETS". THIS PLAN CAN ONLY LEAD TO ULTIMATE RATIONING OF HEALTH CARE SERVICES. THIS BILL HAS STRONG SUPPORT FROM THE BUSH ADMINISTRATION PRESUMABLY BECAUSE IT IS ANOTHER WAY OF CUTTING THE BUDGET.

THE PROBLEM OF THE UNDER-INSURED AND THE PROBLEM OF THE LONG-TERM CARE OF THE ELDERLY ARE THE PRIMARY FOCAL POINTS OF YOUR HEARING TODAY AND I WANTED TO BRING TO YOUR ATTENTION THE IMPACT THAT THESE PROPOSALS COULD HAVE ON THESE GROUPS OF PATIENTS AND INDEED ON ALL PATIENTS. THESE PROPOSALS CAN ONLY RESULT IN A REDUCTION OF HEALTH CARE SERVICES PROVIDED TO THE ONES WHO NEED IT THE MOST.

EXPENDITURE TARGETS WOULD PLACE ARBITRARY GOALS ON THE AMOUNT OF CARE DELIVERED TO OUR PEOPLE AND WOULD EFFECTIVELY

NOT ONLY RATION HEALTH CARE BUT WOULD ESSENTIALLY STOP THE SCIENTIFIC AND TECHNOLOGICAL PROGRESS OF MEDICINE IN ITS TRACKS. IT WOULD ULTIMATELY HAVE GREAT BEARING ON THE ABILITY OF OUR NATION TO CONTINUE RESEARCH IN MEDICINE AND TO CONTINUE THE EXCELLENT MEDICAL EDUCATION PROGRAMS THAT TRAIN THE BEST DOCTORS IN THE WORLD. LET US NOT DISCOURAGE THE CREAM OF OUR YOUTH FROM ENTERING MEDICINE AND FROM REMAINING IN THE PRACTICE OF MEDICINE JUST TO SOLVE A SHORT RANGE PROBLEM.

WE HAVE A GREAT HEALTH CARE SYSTEM IN THIS COUNTRY AT THIS TIME AND IT IS ADVANCING DAILY. TO PLACE A BARRIER AROUND THAT SYSTEM AND MAKE IT DIFFICULT FOR ALL TO PARTICIPATE IN ITS ADVANCES WOULD BE A GREAT MISTAKE. IT WOULD BE LIKE TAKING THE AMERICAN PEOPLE TO SEE THE PROMISED LAND BUT ALSO ERECTING A HUGH CHAIN-LINK FENCE AROUND IT SO THAT WE COULD NOT PARTICIPATE IN IT.

OUR CANADIAN NEIGHBORS HAVE PUT LIMITS ON EXPENDITURES FOR HEALTH CARE WHICH HAVE BEEN QUITE EFFECTIVE IN HOLDING DOLLAR COSTS DOWN BUT POTENTIALLY AT AN ENORMOUS COST TO THE HEALTH OF THE PATIENTS OF THEIR COUNTRY. THESE LIMITS HAVE RESULTED IN GREAT DIFFICULTY IN GAINING ACCESS TO NEEDED SERVICES WITHIN THE SYSTEM AND HAVE LED TO A DETERIORATING QUALITY OF CARE ACCORDING TO THEIR OWN PRESS.

RATIONING OF HEALTH CARE IS BEING OPENLY DISCUSSED IN CANADA. THEIR OWN WEEKLY NEWS MAGAZINE, MACLEAN'S, CLAIMS SOME PATIENTS HAVE DIED AFTER LONG WAITS FOR NEEDED SURGERY. OTHER EXAMPLES OF WHAT HAPPENS WITH EXPENDITURE TARGETS ARE AS FOLLOWS:

* THE WAIT IN VANCOUVER FOR PSYCHIATRIC, NEUROSURGICAL OR ROUTINE ORTHOPEDIC CONSULTATION IS 1-3 MONTHS; THE WAIT IS 6-9 MONTHS FOR CATARACT EXTRACTION, 2-4 YEARS FOR CORNEAL TRANSPLANTATION AND 6-18 MONTHS FOR ADMISSION TO A LONG TERM PLACEMENT BED. OUR ELDERLY IN THIS COUNTRY DESERVE BETTER THAN THAT.

* THE WAIT IN QUEBEC FOR CORONARY ARTERY BYPASS SURGERY IS 8-9 MONTHS, AFTER A PREVIOUS 6 MONTH WAIT FOR THE HEART CATHETERIZATION AND X-RAYS NEEDED TO MAKE THE DIAGNOSIS OF HEART DISEASE.

* CANADIANS HAVE 10% AS MUCH POPULATION AS THE UNITED STATES YET THEY ONLY HAVE 11 HOSPITALS THAT ARE CAPABLE OF PERFORMING OPEN HEART SURGERY, COMPARED TO 793 IN THE U.S.

* MACHINES TO DO MAGNETIC RESONANCE IMAGING, A FIELD IN WHICH I SPECIALIZE, ARE IN GREAT SHORTAGE IN CANADA COMPARED TO THE U.S. THIS NEW TECHNOLOGICAL MIRACLE IS THE GREATEST IMAGING TOOL TO HAVE BEEN INVENTED SINCE THE DISCOVERY OF THE X-RAY IN THE 1890'S. IT AFFORDS DOCTORS THE OPPORTUNITY TO SEE INSIDE CRITICAL AREAS OF THE BODY LIKE THE BRAIN AND THE

SPINAL CORD AND SEE CONDITIONS THEY HAVE NEVER BEEN ABLE TO SEE PREVIOUSLY WITHOUT EXPLORATORY SURGERY. IT SAVES HEALTH CARE DOLLARS BY AVOIDING UNNECESSARY SURGERY BUT MORE IMPORTANTLY IT SAVES LIVES BY NOT OPERATING WHEN NOT NEEDED. CANADA HAD ONLY 12 SUCH UNITS IN 1988 AND IN 1987 WE HAD 900. TODAY WE HAVE OVER 1000 MRI FACILITIES. WHEN ADJUSTMENTS ARE MADE FOR THE SIZE OF THE POPULATION WE HAVE ONE UNIT FOR ABOUT EVERY QUARTER MILLION INHABITANTS WHILE THEY MUST SHARE ONE UNIT WITH OVER TWO MILLION PEOPLE SPREAD OVER AN ENORMOUS AREA.

* THERE ARE MANY MEDICAL SERVICES THAT ARE IN SHORT SUPPLY IN CANADA COMPARED TO THE U.S. THE FOLLOWING TABLE SHOWS THE SIZE OF THE POPULATION WHICH IS SERVED BY ONE OF THE INDICATED MEDICAL SERVICES USING 1988 DATA FOR CANADA AND 1987 DATA FOR THE U.S. (DATA TAKEN FROM THE AMERICAN AND CANADIAN HOSPITAL ASSOCIATIONS, THE CANADIAN MEDICAL ASSC., AND OTHERS):

	U.S.	CANADA
	(NO. OF INHABITANTS	PER UNIT.)
OPEN HEART SURGERY	307,000	2,364,000
CARDIAC CATHETERIZATION	198,000	839,000
ORGAN TRANSPLANTATION	764,000	1,857,000
RADIATION THERAPY	252,000	839,000
SHOCK WAVE LITHOTRIPSY	1,069,000	6,500,000
MAGNETIC RESONANCE	271,000	2,167,000

ONE OF THE MOST OMINOUS SIGNS OF A SERIOUS DETERIORATION OF HEALTH CARE THAT OCCURS FROM TOO MUCH CONTROL OVER THE CARE PATIENTS CAN RECEIVE IS SEEN IN QUEBEC. IN THIS PROVINCE HOSPITALS CLOSE BEDS DURING THE WINTER MONTHS WHEN THEIR BUDGETS BEGIN TO LOOK UNBALANCED. WHAT WOULD AMERICANS SAY IF WE DID THAT AND IF WE HAD A BAD INFLUENZA YEAR THAT WINTER? AND WHAT ABOUT AIDS? WHAT WOULD HAPPEN TO THOSE PATIENTS IF THE EXPECTED INCREASE CONTINUES IN THIS COUNTRY.

ECONOMISTS SAY THAT SHORTAGES BRING ON PRICE CONTROLS AND PRICE CONTROLS BRING ON RATIONING; FURTHER THEY SAY RATIONING BRINGS ON BLACK MARKETS WHICH CERTAINLY CANNOT DO ANYTHING BUT REDUCE QUALITY. PERHAPS WE HAVEN'T SEEN BLACK MARKETS DEVELOP YET BUT WE ALREADY SEE MANY CANADIANS LEAVING THEIR COUNTRY TO SEEK HEALTH CARE IN THE U.S. BECAUSE THEY CANNOT GET WHAT THEY FEEL THEY NEED THERE. WHERE WOULD OUR PEOPLE GO IF OUR QUALITY WENT DOWN-HILL? OR WOULD WE HAVE A TWO-TIER SYSTEM, ONE FOR THE RICH AND ONE FOR EVERYONE ELSE?

BASED ON THIS DISTRESSING SITUATION IN CANADA CONGRESS SHOULD NOT EXPERIMENT ON OUR ELDERLY POPULATION WITH PLANS THAT ARE BASICALLY GOING TO RATION OR OTHERWISE CUT THEIR MEDICAL BENEFITS.

INSTEAD WE SHOULD LOOK TO A PROPOSAL LIKE THAT WHICH CONGRESSMAN GRADISON HAS PROPOSED, ONE IN WHICH PRACTICE PARAMETERS ARE DEVELOPED. THIS CONCEPT IS STRONGLY SUPPORTED NOT ONLY BY THE AMA BUT ALSO BY MANY OF OUR PHYSICIAN SPECIALTY SOCIETIES.

PRACTICE PARAMETERS ARE GUIDELINES WHICH DEFINE TYPICAL EXAMPLES OF HOW OFTEN A PATIENT SHOULD BE SEEN FOR CERTAIN ILLNESSES, HOW AND WHEN LAB TESTS AND X-RAYS ARE USUALLY PERFORMED, WHEN SURGERY IS NEEDED AND WHEN IT IS NOT NEEDED, AND VARIOUS OTHER CHARACTERISTICS OF A TYPICAL PRACTICE.

THESE PRACTICE PARAMETERS WOULD BE ESTABLISHED BY PHYSICIANS AND THEIR MEDICAL ORGANIZATIONS. VARIATIONS TO PRACTICE PARAMETERS WOULD ALWAYS BE ALLOWED BECAUSE MANY PATIENTS DIFFER FROM THE AVERAGE BUT THESE VARIATIONS WOULD BE STUDIED BY OTHER DOCTORS IN ORDER THAT THE PATIENTS WOULD BE GIVEN PROPER TREATMENT BUT YET THAT THE SYSTEM WOULD NOT BE OVERUTILIZED. WE CALL THIS SYSTEM "PEER REVIEW" AND WE BELIEVE IN IT.

THE ROLE OF DOCTORS IN AMERICA AS WELL AS ALL OF THE MEDICAL ORGANIZATIONS BEHIND THEM IS TO PROTECT THE HEALTH OF THE AMERICAN PUBLIC. WE HAVE ALWAYS BELIEVED THAT OUR MISSION IS TO GIVE THE BEST CARE POSSIBLE TO YOU, OUR PATIENTS. IT IS THE PRIVILEGE TO CONTINUE GIVING EXCELLENT CARE FOR WHICH I AM PLEADING TODAY.

OUR POOR, OUR DISABLED, OUR ELDERLY, AND EVERY SINGLE AMERICAN DESERVES TO HAVE EXCELLENT CARE. WE ASK YOU NOT TO BEGIN TO DISMANTLE A SYSTEM WHICH CAN BRING HIGH QUALITY CARE TO THEM FOR THE SAKE OF SHORT RANGE MONETARY SAVINGS.

THE SYSTEM CAN ALWAYS BE IMPROVED AND WE STAND READY TO HELP YOU IN DESIGNING A BETTER SYSTEM BUT PLEASE, OUR PATIENTS DESERVE BETTER THAN TO HAVE THEIR HEALTH CARE BUDGET CUT OUT FROM BENEATH THEM. WE'RE TALKING ABOUT THE CARE NOT ONLY TO OUR ELDERLY BUT ALSO TO YOU, YOUR CHILDREN AND GRANDCHILDREN; WE WANT IT TO BE THERE WHEN ITS NEEDED.

THANK YOU.

Chairman Oakar. Doctor, please proceed. OK. Thank you, Dr. Chardnock. Thank you, Dr. Castele.

Dr. Chardnock. Thank you, Mary Rose Oakar. I have all my written material and I'll paraphrase that as much as I can.

Chairman Oakar. Good. We would be delighted to have your entire statement for our record, doctor.

Dr. Chardnock. Thank you, ma'am.

Chairman Oakar. If you can summarize it, that would be fine.

STATEMENT OF EDWARD L. CHARDNOCK, M.D., FACEP, OHIO STATE MEDICAL ASSOCIATION AND PRESIDENT, OHIO CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Dr. Chardnock. Madam Chairman, members of the committee, I, too, would like to take this opportunity to speak to you and thank you for this opportunity.

I'm concerned about health care issues in Ohio as well as throughout the United States, and as Dr. Castele mentioned, I'm an emergency physician from the Cleveland area, I am board certified in emergency medicine, and I'm the director of a department of emergency medicine that sees approximately 30,000 patients a year. I'm a member of the Ohio State Medical Association, and I'm currently president of the Ohio chapter of the American College of Emergency Physicians.

I'll focus my comments today on the experiences of emergency physicians as they pertain to the issues of the uninsured patients.

Chairman Oakar. Let me say that I have a nephew who just finished his residency at Mount Sinai in emergency medicine, and, Dr. Castele, I think you remember my young nephew when he was a kid trying to work at Lutheran for a few weeks.

I have to tell you, he's told me some horror stories, so I'm interested in hearing your horror stories as well.

Dr. Chardnock. You mean, I may be among friends?

Chairman Oakar. Yeah, well you may be, because it's unbelievable the kinds of patients that he serves and tries to serve as a young person.

Please, proceed.

Dr. Chardnock. Thank you.

Our college supports the concept of health care coverage for as many people as possible. The lack of health care and adequate health insurance is a serious problem in this country, and we as emergency physicians consider it a disgrace since we are one of the richest countries in the world and need to do a much better job in this area than we do.

Although the exact number of uninsured Americans is not known, reliable estimates indicate that approximately 37 million of our fellow citizens under age 65 are uninsured for health care and do not qualify for Medicaid. This is an increase of 15 percent since 1982.

These uninsured are a heterogeneous group and include approximately 12 million people with a reported income of over $20,000 per year. This study was done in 1985, and was done by the Employee Benefits Research Institute.

The study also reported that about 75 percent of these uninsured are either employed full time or part time, or are dependents of these type of workers.

A study by the American College of Emergency Physicians has revealed that 69 percent of the uninsured patients fall into this previous category, that is, they are employed, they are working, but can't afford insurance. Most uninsured employed persons either work for a small firm or are self-employed. These people make too much money to qualify for Medicaid, but find it financially impossible to purchase individual health insurance policies.

We've estimated that 1 million of these people fall into the category of people who are "medically" uninsurable. We've seen several of these people testify already. They have previous poor health status, they have a previous medical history, or in some instances are employed in a medically hazardous occupation.

The American College of Emergency Physicians has conducted its own surveys and agrees with the previous studies. Our studies have also shown that 30 percent of patients who present to emergency departments across the country have no health care insurance. This, obviously, varies according to geographic zone, and in some areas of the country these percentages are much higher.

Within Cuyahoga County, there is a marked variance of the number of uninsured emergency department patients with variants of almost none of these patients in some emergency departments to over 40 percent in others.

I happen to be very fortunate to practice at Parma Hospital, where almost everybody is employed, and so our percentage is lower, but every day I see a number of patients who come to the emergency department who have no insurance and have no other alternative for medical care but to come to the emergency department.

As you know, we are required by law to see every patient that comes into our emergency department, and these policies have imposed on us the responsibility to fill gaps in the health care service delivery system, and we're anxious to fill that gap.

The 1986 Congress required that every patient with complaints in the emergency department, that comes to the emergency department with a complaint, be given an appropriate screening examination. We do this, we comply with the law, and, as you know, if we are asked if we will transfer this patient inappropriately, we will not do so.

In our hospital, if we do that we are—transfer this patient, we are subject to fines. In our hospital, we audit every transfer of patients to other hospitals from our emergency department to make sure we are, indeed, complying with the Federal regulations.

It should be obvious from my comments that emergency medicine has a clear and considerable interest in this issue. We are concerned that with the U.S. health care system becoming more competitive and cost conscious, that the uninsured will experience increasing difficulty in finding access to necessary health care.

We serve as the entry way to the entire health system for other uninsured patients, because the alternative treatment sites may be in short supply or even unavailable in the community.

Access to primary care is a genuine problem. We must direct our attention to improving this part of health care continuum for the uninsured. These uninsured patients face financial barriers, both real and perceived, to primary care services. This is why we find so many of these patients in the emergency departments with maladies such as the flu, cold, or a sprain, that they could adequately be cared for by their primary care physician.

As your nephew is finding out, not every patient that comes to the emergency department is a true, bona fide emergency.

I'll move along quickly, because I think Dr. Castele is going to need my help.

These patients tend to obtain less timely and less regular primary care, and their conditions tend to be more severe when they come to see us.

The AMA and the American College of Emergency Physicians supports legislation that will improve health care and improve access to health care for patients, and we stand ready to assist in preparing this test of this legislation.

ACEP, the American College of Emergency Physicians, has already worked closely with Members of Congress and associations such as the American Association of Retired Persons, to enact health care legislation.

In an effort to be brief, I'll stop here. Once again, I would like to offer my sincere thanks to the committee for allowing Dr. Castele and myself the opportunity to address such a vital issue.

I've attached to my testimony material for your information concerning emergency medicine and emergency physicians.

Thank you very much.

[The prepared statement of Dr. Chardnock follows:]

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OHIO STATE MEDICAL ASSOCIATION

HERBERT E. GILLEN
EXECUTIVE DIRECTOR

D. BRENT MULGREW, J.D.
MANAGING DIRECTOR

TESTIMONY BEFORE THE

UNITED STATES BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE

JULY 6, 1989

PRESENTED BY:
EDWARD L. CHARNOCK, M.D., FACEP

DEPARTMENT OF LEGISLATION
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Serving Ohio's physicians one member at a time.

Madam Chairman and Members of the Committee:

I too would like to thank you for this opportunity to speak to you. I am concerned about health care issues in Ohio as well as throughout the United States. As Dr. Castele mentioned, I am an Emergency Physician from the Cleveland area. I am a Board Certified Emergency Physician and have practiced emergency medicine in this area for six years. I am the Director of a Department of Emergency Medicine and our department sees approximately 30,000 patients per year. I am a member of the Ohio State Medical Association and I am President of the Ohio Chapter of the American College of Emergency Physicians. I will focus my comments on the experiences of emergency physicians as they pertain to the issues of the uninsured patients.

Our Chapter is the third largest Chapter of the American College of Emergency Physicians. The National College represents over 13,000 practicing physicians and the Ohio Chapter has 760 members. The College supports the concept of heath care coverage for as many people as possible.

The lack of adequate Health Insurance coverage is a serious problem in this country and we consider it a disgrace since we are one of the richest countries in the world and need to do a much better job in this area than we do.

Although the exact number of uninsured Americans is not known, reliable estimates indicate that about 37 million of our fellow citizens under age 65 are uninsured for health care costs and do not qualify for Medicaid. This is an increase of 15 percent since 1982. The uninsured are a heterogenous group and include approximately 12 million people with a reported family income of over $20,000 in 1985 according to an Employee Benefits Research Institute study. The study has also reported that about 75 percent of the uninsured are employed either full or part-time or are dependents of these types of workers. A study by the American College of Emergency Physicians reveals that 69 percent of these uninsured fall into the previous category. Most uninsured employed persons either work for a small firm or are self-employed. These persons make too much money to qualify for Medicaid, but find it financially impossible to purchase individual Health Insurance policies.

It is estimated that about 1 million of these uninsured are persons who are cosidered to be "medically uninsurable". These persons are either unable to obtain Health Insurance coverage or can obtain such coverage only at extremely high rates because of poor health status, previous medical history, or employment in a medically hazardous occupation.

The American College of Emergency Physicians has conducted its own surveys and agrees with the Employee Benefits Institute studies and further studies of emergency department visits shows that 30 percent of patients who present to the emergency departments across the country have no health care insurance. This obviously varies according to geographic zone and in some areas of the country are much higher. Within Cuyahoga County there is a marked variance of the number of uninsured emergency department patients with variance of almost none of these patients in some emergency departments to over 40 percent in others.

Over the years we have had to make many changes in order to provide medical care for the individuals who would otherwise not receive care. As an Emergency Physician, I see daily a number of patients who have no alternative but to come into our emergency department for care and have no insurance or other resources to pay for the visit. State and Federal policy requirements imposed on emergency departments have increased the responsibility of emergency physicians and hospital emergency departments to fill gaps in the health services delivery system.

In 1986, Congress required that every patient presenting with complaints to a hospital emergency department be given an appropriate screening examination. The goal of such a screening examination is to determine whether the individual has an emergency medical condition or is in active labor. The law further requires that individuals found to have emergency medical conditions or to be in active labor must either be provided necessary medical treatment to stabilize their condition or appropriately transferred to other medical facilities for further treatment.

It should be obvious from my comments that Emergency Medicine has a clear and considerable interest in the issue of the uninsured patient. We are concerned that with the United States health care system becoming more competitive and cost-conscious, the uninsured will experience increased difficulty in finding access to necessary health care services.

Emergency departments, of course, meet the need for prompt treatment of "bonafide" emergencies that occur and require treatment regardless of a patients emergency insurance status. In addition, emergency departments often serve as the entry way to the entire health system for other uninsured patients, because alternative treatment sites may be in short supply or even unavailable in the community.

Thus emergency departments are frequently the provider of last resort, providing some access to health care for those who are without public or private health insurance protection.

Access to primary care is a genuine problem for many Americans. We must direct our attention to improving this part of the health care continuum for the uninsured. Hospitals in the United States need to work with the commissioner of Public Health to assist in improving public clinics, and to encourage patients with primary and outpatient care needs to seek services in these sites, rather than in hospital emergency rooms.

Uninsured patients face financial barriers, both real and perceived, to primary care services. This is why we find so many of them in hospital emergency rooms with maladies such as the flu, a cold or a sprain, for which insured patients with adequate insurance would have been treated by a primary care physician in an office setting. As a result of the uninsured using emergency rooms as their family physicians, their care is more expensive than care for an insured person who uses a physicians's office or other primary care site. In addition to the higher costs of receiving care in an emergency room, uninsured patients tend to obtain less timely and less regular primary care; their conditions tend to be more severe, and thus the cost of their care increases further.

Also, educational programs need to be targeted at the uninsured to improve their understanding of where to obtain the appropriate health services. This could serve to decrease their health care costs while improving the quality of care they receive.

Another issue I would like to address which that I have seen frequently, is the number of people coming into the emergency room who have been laid off from their work. This is a very trying situation for the person and an illness in the family only festers the feelings of frustrations. Many of those with whom I have talked feel that they are walking on a tight rope, praying that they or one of their children do not come down with even a minor ailment.

The American Medical Association and American College of Emergency Physicians believe that workers who are laid off should have the opportunity to maintain employment-based health insurance for several months after their termination. As a result, the AMA supports legislation that would require employers to offer to continue health coverage for laid-off workers and their dependents for up to four months after the lay-off, with the employer and ex-employee continuing to pay the same percentage of the premium they had paid before the lay-off.

Enactment of this legislation would encourage laid-off employees to continue their health insurance coverage in their former employer's group health plan because they would not have to pay the full premium. In addition, we support the provisions in P.L. 99-272 that requires employers to make group health insurance available for terminated workers at the worker's sole expense for an additional 18 months.

Once again, I offer my sincere thanks to the Committee for allowing Dr. Castele and myself the opportunity to address such a vital issue. Attached to this testimony is material concerning Emergency Medicine and Emergency Physicians for your information.

Chairman **Oakar**. We're delighted to have it. Thank you.

And, as you know, one of our Commissioners is Dr. Davis, representing the AMA point of view, I believe, although I think he's going to be open to lots of different things when we're finished with him. But, seriously, it's going to be a collective kind of situation, where we try to work on a consensus, and that's what it's going to take if we do something in this country.

Dr. **Castele**. He'll do a good job at that.

Chairman **Oakar**. I am sure he will.

Dr. Kenneth Frisof, you are seated next, and we're delighted to have you as well.

STATEMENT OF DR. KENNETH B. FRISOF, EXECUTIVE BOARD, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM; PRESIDENT, NORTHEAST OHIO COALITION FOR NATIONAL HEALTH CARE; AND FAMILY PHYSICIAN, METROHEALTH MEDICAL CENTER

Dr. **Frisof**. I am a family physician at MetroHealth Medical Center. I'm glad to bring an element of debate to the panel this morning, because I'm not sure that Dr. Castele and Dr. Chardnock are going to agree with my positions.

As a family physician, I also want to say that we see the problem of the uninsured, because it's precisely all too many primary care physicians who don't take people without insurance, so they end up getting unnecessarily expensive care in the emergency room.

I'd like to proceed with my statement.

I'm a representative of two organizations you may not have heard of yet, but you'll certainly be hearing from in the future. The first of these is Physicians for National Health Program. Though, we are not yet 3 years old, we have 2,500 members in 50 States. Our membership has tripled in the last 12 months. We are physicians in all forms of practice, united in our belief that the American health care system is in profound disrepair and needs fundamental overhaul.

Our first major accomplishment was writing a national health program for the United States, a physician's proposal, which was published in the January 12, 1989, edition of the New England Journal of Medicine. This article has helped broaden the health policy debate by demonstrating the great potential for professional support a health care system based on the Canadian model would have.

The second organization is the Northeast Ohio Coalition for National Health Care. Our coalition is less than 2 years old, and consists of labor, retirees, community organizations, and health professionals. We are proud to be one of the driving forces behind the introduction in April 1989, by State Representative Robert F. Hagan of Youngstown and 11 cosponsors of House bill 425, the Universal Health Insurance for Ohio Act, or UHIO for short. This pioneering legislation sets out in detail how a single system universal health care program could operate in this State.

Clearly, major change is coming in health care. In addition to our Physicians for a National Health Program proposal, three other national proposals have been made this year: the Enthoven and Kronick Consumer Choice Plan, the National Leadership Commission Plan, the Health Security Partnership Plan, and a fourth plan this morning.

The easy path to change has been laid out by the business professors from Stanford and the National Leadership Commission, and we heard it again this morning: push on employers, especially in small business, to supply insurance and meet some minimal standard; expand government programs to cover the unemployed or marginally and sporadically employed; increase incentives to private groups and individuals to spend their health dollars wisely, in an attempt to hold costs down.

Though, it may be politically easier to get a program like this passed without stirring up intense opposition from rich special interest groups, these patchwork proposals will neither be popular with the people, nor capable of successful implementation. They share the same flaws as our current system.

First, they allow the continuation of financial barriers to care in a misguided approach to cost containment. Asking people with limited incomes to figure out when they are sick enough to make it worthwhile to seek health care, or whether they can afford a preventive screening test are examples of our irrational form of health care rationing. They lead to unnecessary psychological and physical suffering, and we certainly heard about that this morning. And, one of my colleagues in MetroHealth, Dr. Linda Headrick, also spoke pointedly to it a few months ago.

Second, these patchwork proposals continue to permit vast quantities of health care dollars to be squandered on administrative waste. A fragmented, multipayer system is much more expensive to administer than a single universal system. A variety of sources have estimated these excess costs at approximately 10 percent of the money we spend on health care, over $60 billion in 1989.

Is our health really improved by armies of insurance company claims analysts studying each bill to see which services aren't covered or could be paid by another insurer? Is the efficiency of our hospitals improved by having to figure out which services are paid by whom? This 6-foot-long computer printout lists only the 100 or so major payers for care at my hospital, MetroHealth. A printout of the specific payments for specific covered services would probably fill this entire room.

Finally, the patchwork proposals are unlikely to truly hold down costs, as the experience of the past decade has shown. If the politically easy path is a poor choice, in which direction should this Commission go? I, and if public opinion polls are any guide, the vast majority of people in this room would recommend a national health insurance program that covers the entire population in a single system—without financial barriers to care.

We can't have everything. There needs to be cost containment, but the responsibility for it must be placed where it belongs, with physicians and other health professionals, not with individual patients or with insurance company bureaucrats.

Canada's experience over the past 18 years demonstrates that a publicly funded, but privately operated, unitary health care system can provide high quality care at an affordable price. We are pleased that Ohio is the first State in the Nation whose legislature is seriously studying such a system, the Universal Health Insurance for Ohio Act, which is included in the testimony.

The establishment of a single system of national health care is not as giant a leap as it seemed decades ago. The current debate around physician payment reform gives a hint that binding fee schedules are being looked at seriously by the medical profession as an unavoidable part of the practice landscape.

The Pepper Commission's report will help shape the future of the already lively debate on our health care system. While many would predict it to steer a safe course toward multiple private insurer plans, I dare to dream otherwise. There is a political precedent. After Saskatchewan instituted its Provincial Medical Insurance Plan, a Royal Commission was set up at the urging of the Canadian Medical Association, hoping to blunt the reform movement. Instead, the commission's 1964 report recommended the creation of a publicly financed medical insurance system to guarantee that health care be available to all "without hindrance of any kind."

The Pepper Commission has the opportunity to take a bold step forward. Health is not a private commodity, and is, thus, ill-suited to private insurance. It is a social good and can be financed sensibly only by social insurance.

May your step be down the path toward a publicly financed, universal, single system health care program for all Americans.

[The prepared statement of Dr. Frisof follows:]

STATEMENT FOR THE PEPPER COMMISSION ON COMPREHENSIVE HEALTH CARE

JULY 6, 1989

Dr. Kenneth B. Frisof

Executive Board, Physicians for a National Health Program
President, Northeast Ohio Coalition for National Health Care
Family Physician, MetroHealth Medical Center, Cleveland, Ohio

Congresswoman Oakar, members of the Pepper Commission and Staff, and concerned members of the audience:

I am pleased to have the opportunity to make a statement today before the Pepper Commission. Unlike the other esteemed spokespeople on this panel, I come from two organizations you may not have heard of yet, but you will certainly be hearing from in the future.

The first of these is Physicians for a National Health Program. Though we are not yet three years old, we have over 2200 members in all 50 states. Our membership has tripled in the last twelve months. We are physicians in all forms of practice, united in our belief that the American health care system is in profound disrepair and needs fundamental overhaul. Our first major accomplishment was writing "A National Health Program for the United States: a Physicians' Proposal" which was published in the January 12, 1989 issue of the **New England Journal of Medicine**. This article has helped broaden the health policy debate by demonstrating the great potential for professional support a health care system based on the Canadian model would have.

The second organization is the Northeast Ohio Coalition for National Health Care. Our Coalition, less than two years old, consists of labor, retirees, community organizations and health professionals. We are proud to be one of the driving forces behind the introduction in April 1989 by State Representative Robert F. Hagan of Youngstown and eleven cosponsors of HB 425, the Universal Health Insurance for Ohio Act, or UHIO for short. This pioneering legislation sets out in detail how a single-system universal health care program could operate in this state.

Clearly, major change is coming to health care. In addition to the Physicians' Proposal mentioned earlier, three other national proposals have been made so far this year; the Consumer Choice Plan of Professors Enthoven and Kronick, the National Leadership Commission on Health Care's proposal, and the Health Security Partnership plan. The Pepper Commission is under a mandate to release its own proposal this November. Which path will you choose?

The easier path has been laid out by the Business Professors from Stanford and the National Leadership Commission. Push on employers, especially in small business, to supply insurance that meets some minimal standard, and expand government programs to cover the unemployed or marginally and sporadically employed. Increase incentives to private groups and individuals to spend their health dollars "wisely" in an attempt to hold costs down.

Though it may be politically easier to get a program like this passed without stirring up intense opposition from rich special interest groups, these patchwork proposals will neither be popular with the people nor capable of successful implementation. They share the same flaws as our current system.

First, they allow the continuation of financial barriers to care as a misguided approach to cost containment. Asking people with limited incomes to figure out when they are sick enough to make it "worth it" to seek health care or whether they can afford a preventive screening test are examples of our irrational form of health care rationing. They lead to unnecessary psychological and physical suffering. One of my colleagues at MetroHealth Medical Center, Dr. Linda Headrick, spoke poignantly to this issue at a Forum in Cleveland earlier this year.

Secondly, these patchwork proposals continue to permit vast quantities of health care dollars to be squandered on administrative waste. A fragmented multipayor system is much more expensive to administer than a single universal system. A variety of sources have estimated these excess costs at approximately 10% of the money we spend on health care, over $60 billion in 1989. Is our health really improved by armies of insurance company claims analysts studying each bill to see which services aren't covered or could be paid by another insurer? Is the efficiency of our hospitals improved by having to figure out which services will be paid by whom? This six foot long computer printout lists only the 100 or so major plans our hospital bills; a printout of the specific payments for each covered service would probably fill this room.

Finally, the patchwork proposals are unlikely to truly hold down costs, as the experience of the past decade of health care competition has demonstrated.

If the politically easy path is a poor choice, in which direction should the Commission go? I, and if public opinion polls are any guide, the vast majority of people in this room would recommend a national health insurance program that covers the entire population in a single system without financial barriers to care. There needs to be cost containment, but the responsibility for it must be placed where it belongs - with physicians and other health professionals - not with individual patients or insurance company bureaucrats. Canada's experience over the last 18 years demonstrates that a publicly funded but privately operated unitary health care system can provide high quality care at an affordable cost. We are pleased that Ohio is the first state in the nation whose legislature is seriously studying such a system - the Universal Health Insurance for Ohio Act, which I have included as an appendix.

The establishment of a single system of national health insurance is not as giant a leap as it seemed two decades ago. The current debate around physician payment reform gives a hint that binding fee schedules and expenditure targets are being accepted by the medical profession as an unavoidable part of the practice landscape.

The Pepper Commission's report will help shape the future of the already lively debate on our health care system. While many would predict it to steer a safe course towards a multiple private insurer plan, I dare to dream otherwise There is a political precedent. After Saskatchewan instituted its provincial medical insurance plan, a Royal Commission was set up at the urging of the Canadian Medical Association, hoping to blunt the reform movement. Instead the Commission's 1964 Report recommended the creation of a publicly financed medical insurance system to guarantee that health care be "available to all ... without hindrance of any kind."

The Pepper Commission has the opportunity to take a bold step forward. Health is not a private commodity and is thus ill-suited to private insurance; it is a social good and can be financed sensibly only by social insurance. May your step be down the path towards a publicly financed universal single health care system for all Americans.

As Introduced

118th General Assembly
Regular Session
1989-1990

H. B. No. 425

MESSRS. HAGAN-SWEENEY-MS. CAIN-MR. GERBERRY-MMES. PRINGLE-LUCAS-
MESSRS. ROBERTS-SEESE-SYKES-KOZIURA-MMES. CAMPBELL-WHALEN

A BILL

To enact sections 3960.01 to 3960.13 of the Revised Code to provide for the establishment and operation of the Ohio Universal Health Insurance Plan.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 3960.01, 3960.02, 3960.03, 3960.04, 3960.05, 3960.06, 3960.07, 3960.08, 3960.09, 3960.10, 3960.11, 3960.12, and 3960.13 of the Revised Code be enacted to read as follows:

Sec. 3960.01. AS USED IN THIS CHAPTER:

(A) "ELIGIBLE PERSON" MEANS ANY PERSON WHO QUALIFIES FOR BENEFITS UNDER SECTION 3960.09 OF THE REVISED CODE.

(B) "PARTICIPATING PROVIDER" MEANS ANY PERSON THAT IS AUTHORIZED TO FURNISH COVERED SERVICES PURSUANT TO THIS CHAPTER AND RULES ADOPTED BY THE BOARD OF GOVERNORS OF THE OHIO UNIVERSAL HEALTH INSURANCE PLAN.

Sec. 3960.02. THE OHIO UNIVERSAL HEALTH INSURANCE PLAN IS HEREBY CREATED FOR THE PURPOSE OF PROVIDING A SINGLE, PUBLICLY FINANCED STATEWIDE INSURANCE PROGRAM TO PROVIDE COMPREHENSIVE COVERAGE FOR ALL NECESSARY HEALTH CARE SERVICES FOR ALL RESIDENTS OF THIS STATE.

Sec. 3960.03. (A) THE OHIO UNIVERSAL HEALTH INSURANCE PLAN SHALL BE ADMINISTERED BY A BOARD OF GOVERNORS COMPOSED OF NINETEEN MEMBERS, FIFTEEN OF WHOM SHALL BE APPOINTED BY THE GOVERNOR WITH THE ADVICE AND CONSENT OF THE SENATE AND FOUR OF WHOM SHALL BE THE FOLLOWING EX OFFICIO MEMBERS: THE DIRECTOR OF HEALTH, THE DIRECTOR OF HUMAN SERVICES, THE SUPERINTENDENT OF

INSURANCE, AND THE TAX COMMISSIONER. OF THE FIFTEEN APPOINTED MEMBERS, TEN MEMBERS SHALL REPRESENT CONSUMERS AND FIVE SHALL REPRESENT PROVIDERS.

(B)(1) OF THE INITIAL APPOINTMENTS MADE BY THE GOVERNOR, THREE SHALL BE FOR A TERM ENDING DECEMBER 31, 1990, THREE SHALL BE FOR A TERM ENDING DECEMBER 31, 1991, THREE SHALL BE FOR A TERM ENDING DECEMBER 31, 1992, THREE SHALL BE FOR A TERM ENDING DECEMBER 31, 1993, AND THREE SHALL BE FOR A TERM ENDING DECEMBER 31, 1994. THEREAFTER, TERMS OF OFFICE SHALL BE FOR FIVE YEARS, EACH TERM ENDING ON THE THIRTY-FIRST DAY OF DECEMBER.

(2) EACH MEMBER SHALL HOLD OFFICE FROM THE DATE OF HIS APPOINTMENT UNTIL THE END OF THE TERM FOR WHICH HE WAS APPOINTED. ANY MEMBER APPOINTED TO FILL A VACANCY OCCURRING PRIOR TO THE EXPIRATION OF THE TERM FOR WHICH HIS PREDECESSOR WAS APPOINTED SHALL HOLD OFFICE FOR THE REMAINDER OF THAT TERM.

(3) EACH MEMBER SHALL CONTINUE IN OFFICE SUBSEQUENT TO THE EXPIRATION DATE OF HIS TERM UNTIL HIS SUCCESSOR TAKES OFFICE OR UNTIL A PERIOD OF SIXTY DAYS HAS ELAPSED, WHICHEVER OCCURS FIRST.

(C) THE GOVERNOR ANNUALLY SHALL APPOINT THE CHAIRMAN AND SECRETARY OF THE BOARD FROM AMONG THE MEMBERSHIP OF THE BOARD.

(D) MEETINGS SHALL BE HELD UPON THE CALL OF THE CHAIRMAN AND AS MAY BE PROVIDED BY PROCEDURES PRESCRIBED BY THE BOARD.

(E) TEN MEMBERS OF THE BOARD CONSTITUTE A QUORUM, AND THE AFFIRMATIVE VOTE OF TEN MEMBERS SHALL BE NECESSARY FOR ANY ACTION TO BE TAKEN BY THE BOARD.

(F) THE GOVERNOR, AT ANY TIME AFTER NOTICE AND OPPORTUNITY FOR HEARING, MAY REMOVE FOR CAUSE ANY MEMBER APPOINTED BY HIM.

(G) THE MEMBERS OF THE BOARD SHALL SERVE WITHOUT COMPENSATION, BUT SHALL BE REIMBURSED FOR MILEAGE AND THEIR NECESSARY AND ACTUAL EXPENSES INCURRED WHILE ENGAGED IN THE BUSINESS OF THE BOARD.

Sec. 3960.04. (A) THE BOARD OF GOVERNORS OF THE OHIO UNIVERSAL HEALTH INSURANCE PLAN SHALL DO ALL OF THE FOLLOWING:

(1) ESTABLISH BUDGET AND POLICY GUIDELINES FOR THE PLAN;

(2) ESTABLISH FEE SCHEDULES;

(3) DETERMINE AGGREGATE CAPITAL EXPENDITURES;

(4) APPROVE CHANGES IN COVERAGE OFFERED BY THE PLAN;

(5) ADMINISTER AND IMPLEMENT THE PLAN, AND ADMINISTER THE OHIO HEALTH CARE TRUST FUND CREATED UNDER SECTION 3960.06 OF THE REVISED CODE;

(6) ADOPT RULES PURSUANT TO CHAPTER 119. OF THE REVISED CODE;

(7) MONITOR THE OPERATION OF THE PLAN;

(8) STUDY THE MOST EFFECTIVE METHODS OF PROVIDING COMPREHENSIVE PERSONAL HEALTH SERVICES TO ALL PERSONS WITHIN THIS STATE;

(9) REPORT ANNUALLY TO THE GENERAL ASSEMBLY AND THE GOVERNOR ON ITS ACTIVITIES AND RECOMMEND ANY CHANGES IN THE INSURANCE AND HEALTH CARE LAW TO IMPROVE ACCESS TO HEALTH CARE FOR RESIDENTS OF THIS STATE;

(10) DISSEMINATE, TO PROVIDERS OF SERVICES AND TO THE PUBLIC, INFORMATION CONCERNING THE PLAN AND THE PERSONS ELIGIBLE TO RECEIVE THE BENEFITS OF THE PLAN;

(11) STUDY AND EVALUATE THE OPERATION OF THE PLAN, INCLUDING BUT NOT LIMITED TO, THE ADEQUACY AND QUALITY OF SERVICES FURNISHED UNDER THE PLAN, THE COST OF EACH TYPE OF SERVICE, AND THE EFFECTIVENESS OF COST CONTAINMENT MEASURES UNDER THE PLAN;

(12) CONDUCT NECESSARY INVESTIGATIONS AND INQUIRIES AND COMPEL THE SUBMISSION OF INFORMATION, DOCUMENTS, AND RECORDS IT CONSIDERS NECESSARY TO CARRY OUT ITS DUTIES UNDER THIS CHAPTER;

(13) EMPLOY AND SUPERVISE STAFF;

(14) CONDUCT OTHER ACTIVITIES IT CONSIDERS NECESSARY TO CARRY OUT THE PURPOSES OF THIS CHAPTER;

(15) ADOPT RULES PURSUANT TO CHAPTER 119. OF THE REVISED CODE TO ESTABLISH STANDARDS AND PROCEDURES FOR NEGOTIATING AND ENTERING INTO CONTRACTS WITH PARTICIPATING PROVIDERS;

(16) DEVELOP A PLAN OF OPERATION.

(B) THE BOARD, AFTER PROVIDING NOTICE TO CONSUMERS, POLICYHOLDERS, PROVIDERS, THE SUPERINTENDENT OF INSURANCE, AND

ALL OTHER INTERESTED PARTIES, MAY HOLD HEARINGS IN CONNECTION WITH ANY ACTION THAT IT PROPOSES TO TAKE UNDER DIVISION (A) OF THIS SECTION. NOTHING IN THIS DIVISION SHALL BE CONSTRUED AS AUTHORIZING THE BOARD TO ADOPT RULES UNDER DIVISION (A)(6) OR (15) OF THIS SECTION WITHOUT HOLDING PUBLIC HEARINGS.

Sec. 3960.05. (A) THE BOARD OF GOVERNORS OF THE OHIO UNIVERSAL HEALTH INSURANCE PLAN SHALL APPOINT THE EXECUTIVE DIRECTOR OF THE PLAN.

(B) THE EXECUTIVE DIRECTOR SHALL SERVICE AS SECRETARY TO THE BOARD, AND SHALL PERFORM SUCH DUTIES IN THE ADMINISTRATION OF THE PLAN AS THE BOARD MAY ASSIGN.

(C) THE BOARD MAY DELEGATE TO THE EXECUTIVE DIRECTOR ANY OF ITS FUNCTIONS OR DUTIES UNDER THIS CHAPTER OTHER THAN THE ISSUANCE OF RULES AND THE DETERMINATION OF THE AVAILABILITY OF FUNDS AND THEIR ALLOCATION.

Sec. 3960.06. (A) THERE IS HEREBY CREATED IN THE STATE TREASURY THE OHIO HEALTH CARE TRUST FUND, WHICH SHALL CONSIST OF ALL MONEYS OBTAINED FROM TAX REVENUES PURSUANT TO SECTION 3960.13 OF THE REVISED CODE AND FEDERAL PAYMENTS RECEIVED AS A RESULT OF ANY WAIVER OF REQUIREMENTS GRANTED BY THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES UNDER HEALTH CARE PROGRAMS ESTABLISHED UNDER TITLE XVIII AND TITLE XIX OF THE "SOCIAL SECURITY ACT," 49 STAT. 620 (1935), 42 U.S.C. 301, AS AMENDED. MONEYS IN THE FUND SHALL BE USED SOLELY TO ESTABLISH AND MAINTAIN PRIMARY COMMUNITY PREVENTION PROGRAMS, TO PAY PARTICIPATING PROVIDERS, AND TO SUPPORT CONSTRUCTION, RENOVATION, AND EQUIPPING OF HEALTH CARE INSTITUTIONS IN ACCORDANCE WITH SECTION 3960.07 OF THE REVISED CODE AND RULES ESTABLISHED BY THE BOARD OF GOVERNORS OF THE PLAN.

(B) REVENUES HELD IN THE TRUST FUND ARE NOT SUBJECT TO APPROPRIATION OR ALLOTMENT BY THE STATE OR ANY POLITICAL SUBDIVISION OF THE STATE.

(C) THE BOARD OF GOVERNORS SHALL ADMINISTER THE FUND, AND SHALL CONDUCT A QUARTERLY REVIEW OF THE EXPENDITURES FROM AND REVENUES RECEIVED BY THE FUND.

(D) ON AND AFTER JANUARY 1, 1995, THE AMOUNT OF RESERVES IN THE FUND AT ANY TIME SHALL EQUAL AT LEAST THE AMOUNT OF EXPENDITURES FROM THE FUND DURING THE ENTIRE THREE PRECEDING MONTHS.

Sec. 3960.07. (A) THE PREVENTION ACCOUNT IS HEREBY CREATED WITHIN THE OHIO HEALTH CARE TRUST FUND. MONEYS IN THE ACCOUNT SHALL BE USED SOLELY TO ESTABLISH AND MAINTAIN PRIMARY COMMUNITY PREVENTION PROGRAMS, INCLUDING PREVENTIVE SCREENING TESTS. THE BOARD OF GOVERNORS OF THE OHIO UNIVERSAL HEALTH INSURANCE PLAN SHALL ADMINISTER THE ACCOUNT AND, EVERY TWO YEARS, SHALL DETERMINE THE AMOUNT TO BE ALLOCATED TO IT.

(B) THE HEALTH SERVICES ACCOUNT IS HEREBY CREATED WITHIN THE OHIO HEALTH CARE TRUST FUND. MONEYS IN THE ACCOUNT SHALL BE USED SOLELY TO PAY PARTICIPATING PROVIDERS IN ACCORDANCE WITH SECTION 3960.12 OF THE REVISED CODE.

(C) THE CAPITAL ACCOUNT IS HEREBY CREATED WITHIN THE OHIO HEALTH CARE TRUST FUND. MONEYS IN THE ACCOUNT SHALL BE USED SOLELY TO PAY FOR THE SUPPORT OF THE CONSTRUCTION, RENOVATION, AND EQUIPPING OF HEALTH CARE INSTITUTIONS.

Sec. 3960.08. (A) THERE IS HEREBY CREATED WITHIN THE STATE TREASURY THE HEALTH PROFESSIONAL EDUCATION AND TRAINING FUND WHICH SHALL CONSIST OF ALL MONEYS RECEIVED FROM FEDERAL HEALTH PROFESSIONS TRAINING FUNDS. MONEYS IN THIS ACCOUNT SHALL BE USED SOLELY TO PAY FOR THE EDUCATION AND TRAINING OF HEALTH PROFESSIONALS.

(B) DURING THE FIVE-YEAR PERIOD COMMENCING JANUARY 1, 1990 AND ENDING DECEMBER 31, 1994, THE ANNUAL AMOUNT OF STATE EXPENDITURES FOR THE EDUCATION AND TRAINING OF HEALTH PROFESSIONALS SHALL NOT BE REDUCED BELOW THE LEVEL OF SUCH EXPENDITURES IN CALENDAR YEAR 1989.

Sec. 3960.09. EVERY PERSON WHO IS A RESIDENT OF THIS STATE IS ELIGIBLE TO RECEIVE BENEFITS FOR COVERED SERVICES UNDER THE OHIO UNIVERSAL HEALTH INSURANCE PLAN.

Sec. 3960.10. (A) EVERY ELIGIBLE PERSON IS ENTITLED TO RECEIVE BENEFITS FOR ANY COVERED SERVICE FURNISHED WITHIN THIS

STATE BY A PARTICIPATING PROVIDER, IF THE SERVICE IS NECESSARY OR APPROPRIATE FOR THE MAINTENANCE OF HEALTH OR FOR THE DIAGNOSIS OR TREATMENT OF, OR REHABILITATION FOLLOWING, INJURY, DISABILITY, OR DISEASE.

(B) COVERED SERVICES INCLUDE, BUT ARE NOT LIMITED TO, ALL OF THE FOLLOWING:

(1) PRESCRIPTION MEDICATIONS, SUBJECT TO A COPAYMENT OF ONE DOLLAR PER PRESCRIPTION;

(2) AMBULATORY MENTAL HEALTH VISITS. THE BOARD OF GOVERNORS SHALL ESTABLISH THE NUMBER OF ANNUAL VISITS FOR WHICH THERE IS NO CHARGE. THE BOARD MAY REQUIRE COPAYMENTS FOR EXTENDED THERAPY UNDER CIRCUMSTANCES THAT IT DETERMINES.

(3) TREATMENT IN A FACILITY FOR SUBSTANCE ABUSE. ADMISSION TO A FACILITY SHALL BE LIMITED TO ONE PER YEAR. AFTER AN INSURED HAS BEEN ADMITTED THREE TIMES, A REVIEW BOARD, APPOINTED BY THE BOARD OF GOVERNORS, SHALL STUDY INDIVIDUAL REFERRALS FOR SUBSEQUENT ADMISSIONS.

(C) COVERED SERVICES DO NOT INCLUDE ANY OF THE FOLLOWING:

(1) SURGERY FOR COSMETIC PURPOSES OTHER THAN FOR RECONSTRUCTIVE SURGERY;

(2) MEDICAL EXAMINATIONS CONDUCTED AND MEDICAL REPORTS PREPARED FOR EITHER OF THE FOLLOWING PURPOSES:

(a) PURCHASING OR RENEWING LIFE INSURANCE;

(b) PARTICIPATING AS A PLAINTIFF OR DEFENDANT IN A CIVIL ACTION FOR THE RECOVERY OR SETTLEMENT OF DAMAGES.

(3) BASIC CARE RENDERED IN A NURSING HOME.

(D) INSURERS, EMPLOYERS, AND OTHER PLANS MAY OFFER BENEFITS THAT DO NOT DUPLICATE COVERAGE THAT IS OFFERED BY THE PLAN, BUT MAY NOT OFFER BENEFITS THAT DUPLICATE COVERAGE THAT IS OFFERED BY THE PLAN.

Sec. 3960.11. (A) NO PARTICIPATING PROVIDER SHALL REFUSE TO FURNISH SERVICES TO AN ELIGIBLE PERSON ON THE BASIS OF RACE, COLOR, INCOME LEVEL, NATIONAL ORIGIN, RELIGION, SEX, SEXUAL ORIENTATION, OR OTHER NON-MEDICAL CRITERIA.

(B) AN ELIGIBLE PERSON MAY CHOOSE ANY PARTICIPATING PROVIDER, INCLUDING ANY PHYSICIAN WHETHER PRACTICING ON AN INDEPENDENT BASIS, IN A SMALL GROUP, OR IN A CAPITATED PRACTICE. AN ELIGIBLE PERSON WHO ENROLLS IN A CAPITATED PRACTICE MAY CHANGE PROVIDERS ONLY AT STIPULATED INTERVALS, WHICH MAY NOT BE MORE OFTEN THAN ONCE EACH YEAR.

(C) THE OHIO UNIVERSAL HEALTH INSURANCE PLAN SHALL REIMBURSE PARTICIPATING PROVIDERS THAT ARE LOCATED OUTSIDE THIS STATE AT REASONABLE RATES FOR CARE RENDERED TO ENROLLEES WHILE OUTSIDE OF THIS STATE.

(D) EVERY PARTICIPATING PROVIDER SHALL FURNISH SUCH INFORMATION AS MAY BE REASONABLY REQUIRED BY THE BOARD OF GOVERNORS OF THE PLAN FOR UTILIZATION REVIEW, FOR THE MAKING OF PAYMENTS, AND FOR STATISTICAL OR OTHER STUDIES OF THE OPERATION OF THE PLAN.

(E) EVERY PARTICIPATING PROVIDER SHALL PERMIT THE BOARD OF GOVERNORS TO EXAMINE ITS RECORDS AS MAY BE NECESSARY FOR VERIFICATION OF PAYMENT.

Sec. 3960.12. (A)(1) THE OHIO UNIVERSAL HEALTH INSURANCE PLAN SHALL PAY THE EXPENSES OF INSTITUTIONAL PROVIDERS OF INPATIENT SERVICES ON THE BASIS OF GLOBAL BUDGETS THAT ARE APPROVED BY THE BOARD OF GOVERNORS OF THE PLAN.

(2) EACH INSTITUTIONAL PROVIDER SHALL NEGOTIATE AN ANNUAL BUDGET WITH THE PLAN TO COVER ITS ANTICIPATED SERVICES FOR THE NEXT YEAR BASED ON PAST PERFORMANCE AND PROJECTED CHANGES IN FACTOR PRICES AND SERVICE LEVELS.

(3) EVERY PHYSICIAN OR OTHER PROVIDER EMPLOYED BY A GLOBALLY BUDGETED INSTITUTIONAL PROVIDER SHALL BE PAID THROUGH AND IN A MANNER DETERMINED BY THE INSTITUTIONAL PROVIDER.

(B)(1) THE PLAN SHALL REIMBURSE INDEPENDENT PROVIDERS OF HEALTH CARE SERVICES ON A FEE-FOR-SERVICE BASIS. THE PLAN SHALL ANNUALLY NEGOTIATE THE FEE SCHEDULE WITH THE APPROPRIATE PROFESSIONAL GROUP. THE FEE SCHEDULE SHALL BE APPLIED TO HEALTH CARE SERVICES RENDERED BY INDEPENDENT PROVIDERS THROUGHOUT THE STATE.

(2) A PROVIDER MAY NOT CHARGE RATES THAT ARE HIGHER THAN THE NEGOTIATED REIMBURSEMENT LEVEL.

(3) A PROVIDER MAY NOT CHARGE SEPARATELY FOR COVERED SERVICES UNDER SECTION 3960.10 OF THE REVISED CODE.

(C) A MULTISPECIALTY ORGANIZATION OF PROVIDERS MAY ELECT TO BE REIMBURSED ON A CAPITATION BASIS, IN LIEU OF THE FEE-FOR-SERVICE BASIS. PAYMENT ON A CAPITATION BASIS DOES NOT INCLUDE SERVICES RENDERED FOR INPATIENT SERVICES BY INSTITUTIONAL PROVIDERS.

Sec. 3960.13. (A) AS USED IN THIS SECTION:

(1) "EMPLOY" MEANS TO SUFFER OR TO PERMIT TO WORK.

(2) "EMPLOYER" MEANS THE STATE OF OHIO, ITS INSTRUMENTALITIES, AND ITS POLITICAL SUBDIVISIONS AND THEIR INSTRUMENTALITIES, ANY INDIVIDUAL, PARTNERSHIP, ASSOCIATION, CORPORATION, BUSINESS TRUST, OR ANY PERSON OR GROUP OF PERSONS, ACTING IN THE INTEREST OF AN EMPLOYER IN RELATION TO AN EMPLOYEE.

(3) "EMPLOYEE" MEANS ANY INDIVIDUAL WHO WORKS FOR AN EMPLOYER.

(4) "RESIDENT" HAS THE MEANING GIVEN IN SECTION 5747.01 OF THE REVISED CODE;

(5) "INTEREST" HAS THE MEANING GIVEN IN SECTION 6049(b) OF THE INTERNAL REVENUE CODE OF 1986, 100 STAT. 2085, 26 U.S.C. 1, AS AMENDED;

(6) "DIVIDEND" HAS THE MEANING GIVEN IN SECTION 316 OF THE INTERNAL REVENUE CODE OF 1986, 100 STAT. 2085, 26 U.S.C. 1, AS AMENDED;

(7) "PRICE" MEANS THE TOTAL COST OF THE PROPERTY PURCHASED AT RETAIL SALE INCLUDING ANY OTHER TAXES INCLUDED IN THAT COST.

(B) FOR THE PURPOSE OF PROVIDING REVENUE FOR THE OHIO UNIVERSAL HEALTH INSURANCE PLAN, AND TO PAY THE EXPENSES OF ADMINISTERING THE TAXES, THE FOLLOWING TAXES ARE HEREBY LEVIED:

(1) ON EACH EMPLOYER, A TAX EQUAL TO EIGHT PER CENT OF THE EMPLOYER'S PAYROLL;

(2) ON EACH EMPLOYEE, A TAX EQUAL TO ONE PER CENT OF THE EMPLOYEE'S GROSS SALARY OR WAGE;

(3) ON EACH RESIDENT WHO RECEIVES INTEREST IN AN AMOUNT EXCEEDING ONE THOUSAND DOLLARS PER YEAR, A TAX EQUAL TO TWO PER CENT OF THE INTEREST SO RECEIVED;

(4) ON EACH RESIDENT WHO RECEIVES DIVIDENDS IN AN AMOUNT EXCEEDING ONE THOUSAND DOLLARS PER YEAR, A TAX EQUAL TO TWO PER CENT OF THE DIVIDENDS SO RECEIVED;

(5) IN ADDITION TO THE TAXES LEVIED BY CHAPTERS 5739., 5741., AND 5743. OF THE REVISED CODE ON ANY OF THE FOLLOWING PRODUCTS, A TAX ON THE SALE AT RETAIL OF CIGARETTES, CIGARS, SNUFF, AND OTHER TOBACCO PRODUCTS EQUAL TO TEN PER CENT OF THE PRICE;

(6) IN ADDITION TO THE TAXES LEVIED BY CHAPTERS 4301., 4305., AND 4309. OF THE REVISED CODE ON ANY OF THE FOLLOWING PRODUCTS, A TAX ON THE SALE AT RETAIL OF WINE, SPARKLING AND CARBONATED WINE AND CHAMPAGNE, VERMOUTH, BEER, MALT LIQUOR, AND MIXED BEVERAGES, EQUAL TO TEN PER CENT OF THE PRICE;

(7) A TAX ON THE SALE AT RETAIL OF SPIRITUOUS LIQUOR OF TEN PER CENT OF THE PRICE.

(C) THE BOARD OF GOVERNORS OF THE OHIO UNIVERSAL HEALTH INSURANCE PLAN SHALL ADOPT RULES PURSUANT TO CHAPTER 119. OF THE REVISED CODE REGARDING THE LEVY AND COLLECTION OF THE TAXES DESCRIBED IN DIVISION (B) OF THIS SECTION, AND MAY ENTER INTO CONTRACTS WITH THE DEPARTMENTS OF TAXATION AND LIQUOR CONTROL AND THE INDUSTRIAL COMMISSION FOR THE COLLECTION OF THE TAXES LEVIED BY THIS SECTION.

Section 2. Section 1 of this act shall take effect on January 1, 1990.

Section 3. Not later than March 31, 1990, the Department of Human Services shall do both of the following:

(A) Apply to the United States Secretary of Health and Human Services for all waivers of requirements under health care programs established under Title XVIII and Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, that are necessary to enable this state to deposit all federal payments under those programs in the state treasury to the credit of the Ohio Health Care Trust Fund created in section 3960.06 of the Revised Code;

(B) Identify any other federal programs that provide federal funds for payment of health care services to individuals. The Department shall comply with any requirements under those programs and apply for any waivers of those requirements that are necessary to enable this state to deposit such federal funds to the credit of the Ohio Health Care Trust Fund.

Section 4. The Director of Health shall prepare, in cooperation with the Departments of Aging, Human Services, Insurance, and Taxation and the Office of Budget and Management, a report identifying and evaluating the probable effects on the quality and costs of health care in this state that would result from requiring that all money that local governmental agencies raise through locally imposed taxes and currently spend for local health care be deposited instead in the state treasury to the credit of the Ohio Health Care Trust Fund created by section 3960.06 of the Revised Code, as enacted by this act. The Department of Health shall serve as lead agency and provide staff services and office facilities as needed for preparation of the report. On or before December 31, 1991, the Director of Health shall submit the report to the Speaker of the House of Representatives, the President of the Senate, and the Governor.

Section 5. (A) The taxes that are authorized under section 3960.13 of the Revised Code, as enacted by this act, shall be levied commencing January 1, 1991.

(B) Any employer whose employee health benefit costs, on January 1, 1991, exceed eight per cent of its payroll may continue its existing coverage until the expiration of the plan or contract that provides for this coverage. Upon the expiration of the plan or contract, the employer shall convert to coverage under the Ohio Universal Health Insurance Plan.

(C) Any employer whose employee health benefit costs, on January 1, 1990, are less than eight per cent of its payroll shall pay to the Ohio Health Care Trust Fund the amount by which its current payments are less than eight per cent.

(D) Any employer that, on January 1, 1990, does not make any payments for health care for its employees may pay a four per cent payroll tax in 1991, and an eight per cent payroll tax in every subsequent year, pursuant to section 3960.13 of the Revised Code.

Section 6. Not later than February 28, 1990, the Governor shall make the initial appointments to the Board of Governors of the Ohio Universal Health Insurance Plan pursuant to section 3960.03 of the Revised Code, as enacted by this act.

Chairman **Oakar**. Thank you, doctor.

And, I know that family practice program is wonderful.

Mr. Gillespie, you are the vice president of planning and marketing at Greater Cleveland Hospital Association, am I correct about that?

Mr. **Gillespie**. I'm vice president of planning and marketing at the MetroHealth System.

Chairman **Oakar**. MetroHealth System, I apologize. Would you, just for the record, state your name and whom you represent.

STATEMENT OF JOHN GILLESPIE, VICE PRESIDENT OF PLANNING AND MARKETING, METROHEALTH SYSTEM, TESTIFYING ON BEHALF OF HENRY MANNING, PRESIDENT, METROHEALTH SYSTEM

Mr. **Gillespie**. I'm John Gillespie, and I'm vice president of planning and marketing for MetroHealth System, and I'm here on behalf of Henry Manning, who, as Representative Oakar said, had to leave unexpectedly. So, I will present his testimony.

Chairman **Oakar**. Very good, thank you.

Mr. **Gillespie**. MetroHealth is a multihospital system and is the largest public hospital program and Medicaid provider in the State of Ohio. For those of you in the audience who are not familiar with the name MetroHealth, we just changed and previously were known as the Cuyahoga County Hospital System.

I'm here today not only representing the MetroHealth System, but also the 46 other hospital members of the Greater Cleveland Hospital Association, the oldest and one of the largest metropolitan hospital associations in the United States. I want to express the appreciation of all Cleveland area hospitals to Representative Oakar for bringing your Commission to Cleveland today.

There are important initiatives underway here that have put northeast Ohio health care providers in the forefront on many pressing national health care issues. I would like to describe some that are related to the growing numbers of people who lack health insurance.

Let me begin by saying that the Cleveland region presents a health care paradox which is typical to other parts of the country. In this region, we have one of the Nation's strongest and most capable medical communities. The quality and quantity of available health services is exceptional. However, at the same time, accessibility to these services for the population is limited by the appalling number of persons across greater Cleveland without health insurance coverage.

The hospital association recently commissioned a study conducted by the Center for Regional Economic Issues at Case Western Reserve University which utilized the current population survey of the U.S. Census Bureau to determine the number of uninsured in our region. The study revealed that there were 213,000 persons, or 11.4 percent of the greater Cleveland population, without any health insurance coverages.

Additionally, the study showed that of those uninsured 37,000 had jobs, a lot of what you've heard about today, and 33,700 were children under the age of 15.

About one-half of all the uninsured were low-income families. Any serious illness in these families would clearly cause financial stress and hardship beyond their means.

What we have found in MetroHealth, and I'm sure all other hospitals that serve the uninsured, is that persons without health insurance can be expected to wait until they are seriously ill before seeking care, making their treatment much more expensive and their recovery much more difficult. And, as Dr. Chardnock has mentioned, their first entry point or contact for service will most likely be the emergency room, which as those of us in the business know, is an inordinately expensive means of getting medical care.

The lack of health insurance is also causing Cleveland, like other areas of the country, to lose some of its future potential through increased mortality rates among newborn infants. The significance of access to quality prenatal care for expectant mothers who do not have health insurance is demonstrated by the impact of the MetroHealth Maternity and Infant Care Program. This program, begun in 1965, is funded by the Federal and State governments and by MetroHealth, and it's designed to provide comprehensive health care services to poor women and their newborns, with emphasis on outreach and prenatal care.

Approximately 6,000 women and 3,000 children receive MetroHealth's maternity and infant care [M&I] services each year, at several locations throughout the city and county.

Success of this early intervention is demonstrated by the fact that the recent mortality rates for the first 28 days of life stood at 15.5 infants per 1,000 for Cleveland, 11.3 infants per 1,000 for Cuyahoga County, and in the same year the rate among M&I participants, again, these are poor women, who are mainly inner-city residents, was only 10.3 percent per 1,000, 10.3 per 1,000.

While the M&I staff would like the rate to be even lower, the statistical fact is that good prenatal care has reduced infant mortality by one-third relative to the averages for the city.

Because of the serious concern about declining health insurance protection rates, the Greater Cleveland Hospital Association has joined with the Federation of Community Planning and a number of State legislators in creating a new program which will target small employers who want to provide health care benefits for their employees but cannot afford to do it alone. Governor Celeste strongly endorses this program, and the Ohio General Assembly has just approved a 2-year demonstration project which will fund three or four new programs to provide the working uninsured with health benefits.

The hospital association is now working with a number of organizations to develop a demonstration project in the greater Cleveland area. Based on the success of these various demonstration projects, concerned leadership in Ohio and the legislation will be able to more adequately address the problem with longer term solutions.

We have great hopes that this type of innovation will be an important gap filler for at least the working uninsured, and will set an example for others across the country who want to tackle this serious social dilemma.

Madam Chairman, Cleveland Hospital, especially MetroHealth, as the Nation's 1988 recipient of the Foster T. McGaw award for community service. We take great pride in their record for service to the community, including charity care for the poor.

Hospitals in northeast Ohio are certainly doing their share in caring for the uninsured. In fact, Cleveland's hospitals spent over $114 million in 1987 to provide care to persons who either could not or would not pay their bills. The amount of this so-called uncompensated care has risen steadily over the past few years. In 1984, it amounted to $98 million, and has increased 16 percent to 1987.

Nationally and locally, private not-for-profit hospitals may be reaching the breaking point in the amount of free care they are able to provide, and, likewise, public hospitals, such as MetroHealth, are not in a position to carry an increased burden. With ever-threatening cuts in Medicare and Medicaid reimbursement, which provides more than 50 percent of the average hospital's total patient revenue, most hospitals are hard pressed to maintain present levels of care. Hospital executives are gratified that the Congress this year demonstrated its concern for the elderly and the hospitals by not making further drastic cuts in Medicare, and the crucial leadership you provided to that effort, Congresswoman.

Payment reductions have been compounded by steeply rising inflation in the health care market basket. In reference to rising health care costs, I would like to mention that the hospitals in northeast Ohio had some success over the past few years in keeping their costs down, as compared to other parts of the country.

Attached to my testimony is a copy of the hospital association's report to the community, which addresses the issues of the Cleveland area hospital cause. Inside, you'll see reference to the fact that hospital and patient cost increases ranged between 5.5 and 5.9 percent, compared to the 9 percent averages across the country.

While we are proud of this result, the hospital association intends to work with the area's business community and others to pursue continuing shared efforts to address quality costs and access issues.

Madam Chairman, in conclusion, Cleveland's hospitals stand ready to work with all interested parties to find answers to the health care challenges this country now faces. We are pleased that the Commission on Comprehensive Health Care recognizes that these challenges will not be met if the sole responsibility is placed at the steps of the Nation's hospital community.

Only through the concerted efforts of medical institutions in conjunction with State legislatures, the Congress, the health insurance industry, the business community, and others will workable solutions be found.

On behalf of the MetroHealth System, and speaking for the Greater Cleveland Hospital Association, I am pleased to have had this opportunity to assist the Pepper Commission in your goals to improve the country's health care system.

Thank you.

[The prepared statement of Mr. Manning follows:]

STATEMENT OF HENRY E.MANNING

PRESIDENT AND CHIEF EXECUTIVE OFFICER
THE METROHEALTH SYSTEM
CLEVELAND, OHIO

Before the

U. S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

July 6, 1989

Madam Chairman, and members of the Commission. My name is Henry Manning. I'm the President and Chief Executive Officer of the MetroHealth System based here in Cleveland. MetroHealth is a multi-hospital system and the largest public hospital program and Medicaid provider in the State of Ohio.

I am here today not only representing the MetroHealth System but also the 46 other hospital members of the Greater Cleveland Hospital Association -- the oldest and one of the largest metropolitan hospital associations in the United States.

I want to express the appreciation of all Cleveland area hospitals to Representative Oakar for bringing your Commission to Cleveland. There are important initiatives underway here that put Northeast Ohio healthcare providers in the forefront on many pressing national healthcare issues. I would like to describe some that are related to the growing numbers of people who lack health insurance.

Let me begin by saying that the Cleveland region presents a health care paradox which is typical of other parts of the country. In this region we have one of the nation's strongest and most capable medical communities. The quality and quantity of available health care services is exceptional. However, at the same time accessibility to these services for the population is limited by the appalling number of persons across Greater Cleveland without health insurance protection.

The Hospital Association recently commissioned a study, conducted by the Center for Regional Economic Issues at Case Western Reserve University which utilized The Current Population Survey of the United States Census Bureau to determine the number of uninsured in our region. The study revealed that there are 213,000 persons or 11.4% of the Greater Cleveland population without any healthcare insurance coverages.

Additionally, the study showed that of those uninsured, 37,000 had jobs and 33,700 were children under the age of 15.

About one half of all the insured were low income families. Any serious illness in these families would clearly cause financial stress and hardship beyond their means.

What we have found at MetroHealth, and I'm sure at all other hospitals which serve the uninsured, is that persons without health insurance can be expected to wait until they're seriously ill before seeking care, making their treatment much more expensive and their recovery much more difficult. Their first point of contact for service will most likely be the emergency room, which is an inordinately expensive means of medical care.

The lack of health insurance is also causing Cleveland, like other areas of the country, to lose some of its future potential through increased mortality rates among newborn infants. The significance of access to quality pre-natal care for expectant mothers who do not have health insurance is demonstrated by the impact of the MetroHealth Maternal and Infant Care Program. This program, begun in 1965, is funded by the Federal and State Governments and by MetroHealth and is designed to provide comprehensive health care services to poor women and their newborns, with emphasis on outreach and pre-natal care.

Approximately 6,000 women and 3,000 children receive MetroHealth's Maternal and Infant Care services each year at several locations in the city. The success of this early intervention is demonstrated by the fact that in 1987 (the latest statistics available), the regional mortality rates for the first 28 days of life stood at 15.5 infants per 1,000 for Cleveland and 11.3 per 1,000 for Cuyahoga County, while the rate among M&I participants who are mainly inner city residents was only 10.3 per 1,000. While our M&I staff would like the rate to be even lower, the statistical fact is that good prenatal care has reduced infant mortality by one third relative to averages for the city.

Because of the serious concern about declining health insurance protection rates the Greater Cleveland Hospital Association has joined with the Federation for Community Planning and a number of state legislators in creating a new program which will target small employers who want to provide healthcare benefits for their employees but cannot afford to do it alone.

Governor Celeste strongly endorses this program and the Ohio General Assembly has just approved a two-year demonstration project plan which will fund three or four new programs to provide the working uninsured with health benefits. The Hospital Association is now working with a number of organizations to develop a demonstration project in the Greater Cleveland area. Based on the success of these various demonstration projects, concerned leadership in Ohio and the legislature will be able to more adequately address the problem with longer term solutions.

We have great hopes that this type of innovation will be an important gap filler for at least the working uninsured and will set an example for others across the country who want to tackle this serious social dilemma.

Madam Chairman, Cleveland's hospitals, especially MetroHealth as the nation's 1988 recipient of the Foster G. McGaw award for community service, take great pride in their record for service to the community including charity care for the poor. Hospitals in northeast Ohio are certainly doing their share in caring for the uninsured. In fact, Cleveland's hospitals spent about $114 million in 1987 to provide care to persons who either could not or would not pay their bills. The amount of this so-called uncompensated care has risen steadily over the past few years. In 1984 it amounted to $98 million and had increased 16 percent by 1987.

Nationally and locally private not-for-profit hospitals may be reaching the breaking point in the amounts of "free" care they are able to provide and, likewise public hospitals are not in a position to carry an increased burden. With ever-threatening cuts in Medicare and Medicaid reimbursement, which provides more than 50 percent of the average hospital's total patient revenue, most hospitals are hard pressed to maintain present levels of care. Hospital executives were gratified that the Congress this year demonstrated its concern for the elderly and hospitals by not making further drastic cuts in Medicare payments.

Payment reductions have been compounded by steeply rising inflation in the health care market basket. In reference to rising health care costs, I would like to mention that hospitals in northeast Ohio had some success over the past few years in keeping their costs down, as compared to other parts of the country.

Attached to my testimony is a copy of a Hospital Association's report to the community which addresses the issue of Cleveland area hospital costs. Inside you'll see reference to the fact that hospital inpatient cost increases here ranged between 5.5 and 5.9 percent, compared to 9 percent averages across the country.

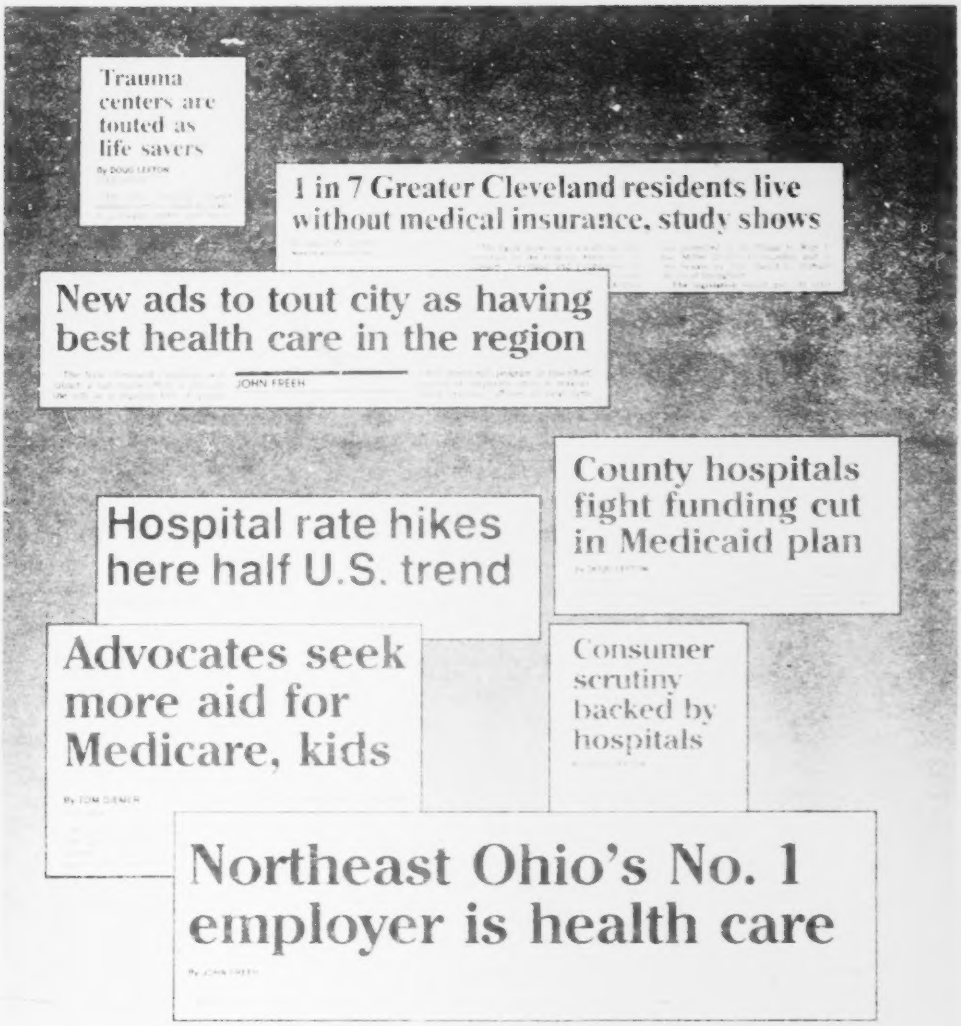
While we are proud of this result, the Hospital Association intends to work with the area's business community and others -- to pursue continuing shared efforts to address quality, cost and access issues.

Madame Chairman, in conclusion, Cleveland's hospitals stand ready to work with all interested parties to find answers to the health care challenges this country now faces. We are pleased that the Commission on Comprehensive Health Care recognizes that these challenges will not be met if the sole responsibility is placed at the steps of the nation's hospital community. Only through the concerted efforts of our medical institutions in conjunction with state legislators, the congress, the health insurance industry, the business community and others will workable solutions be found.

On behalf of the MetroHealth System and speaking for the Greater Cleveland Hospital Association I am pleased to have had this opportunity to assist the Pepper Commission in your goals to improve the country's health care system.

Thank you.

Greater Cleveland Hospital Association



Trauma centers are touted as life savers

By DOUG LEFTON

1 in 7 Greater Cleveland residents live without medical insurance, study shows

New ads to tout city as having best health care in the region

JOHN FREEH

County hospitals fight funding cut in Medicaid plan

Hospital rate hikes here half U.S. trend

Advocates seek more aid for Medicare, kids

By TOM DIEMER

Consumer scrutiny backed by hospitals

Northeast Ohio's No. 1 employer is health care

By JOHN FREEH

Working for Your Good Health

This year's Report to the Community is designed to give you an idea of our many challenges and successes.

We bring this story to the public because so much of what we do affects everyone's quality of life. It's no wonder that the public ranked health care as its number one concern—above crime, drugs, taxes or schools—in a recent opinion survey.

The Greater Cleveland Hospital Association exists because this area's hospital leadership believes much public good can be accomplished by working together.

For example, we have been fighting to preserve the nation's Medicare program from draconian budget cuts which threaten the very survival of hospitals here. We are working to develop the state's first regional trauma network in an effort to save more lives. We are also seeking solutions to the growing indigent care crisis.

These are issues which affect all of us, and our hospitals have been in the forefront.

Of course, what hospitals themselves do best is care for people. And maintaining excellent quality—even during times of financial stress—is the first priority of every hospital.

This is why we are working to develop quality of care indicators which will help the public make better healthcare decisions. We are also working with members of the business community on quality issues to help them become more informed consumers. In short, the hospital industry is committed to serving the public.

We hope this Report to the Community reflects that commitment to you.

David H. Plate Chairman Executive Council	C. Wayne Rice, Ph.D. President, Greater Cleveland Hospital Association	Albert E. Fowerbaugh Chairman Board of Trustees

"Putting a Lid" on Rising Healthcare Costs

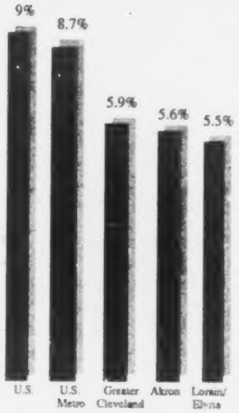
Northeast Ohio hospitals have been working for several years to "put a lid" on rising healthcare costs, and that effort is showing results, according to two surveys. A cross section of hospitals around Greater Cleveland responding to a survey showed the average rate increase for 1989 was expected to be 4.3 percent.

> **"Citing the competitive marketplace, hospital officials here have instituted average rate increases of less than 5% for 1989, a figure well below estimated 8% to 10% rate hikes nationally."**
>
> Crain's Cleveland Business,
> January 16, 1989

This survey was highlighted in in a Crain's Cleveland Business article which compared the local price hikes with the rest of the nation. Rate hikes here are expected to be half the national average. The key to pricing restraints is competition. Consumers are always looking for the best price without sacrificing quality, and hospital leaders have been very sensitive to the marketplace.

According to a national survey by the American Hospital Association, Greater Cleveland hospitals are doing much better than the national average in containing healthcare costs.

The AHA's annual statistical report, recently released for 1987, showed the average cost per case (inpatient) jumped 9 percent. The average U.S. metropolitan average rose 8.7 percent. The increase in Greater Cleveland was 5.9 percent, 5.6 percent in Akron and 5.5 percent in Lorain/Elyria.



1987 cost-per-case (inpatient) increases

Source: AHA

Industry pumps $7-$9 Billion into Northeast Ohio Economy

Top Five Employers in Greater Cleveland/Akron /Lorain-Elyria

HEALTH SERVICES	**99,903 Employees**
EATING AND DRINKING PLACES	**69,550**
BUSINESS SERVICES	**53,200**
WHOLESALE TRADE-DURABLE GOODS	**53,176**
FABRICATED METAL PRODUCTS	**49,112**

Annual Payroll Expenses of Top Five Employers ($1,000)

HEALTH SERVICES	**$ 2,071,899**
WHOLESALE TRADE -D.G.	1,387,282
FABRICATED METAL PRODUCTS	1,321,597
BUSINESS SERVICES	825,341
EATING AND DRINKING PLACES	429,540

Source: U.S. Bureau of the Census

The health services industry's direct and indirect contribution to our regional economy amounted to $6.8 billion and $9.3 billion. That's according to a study conducted by Cleveland State University researchers.

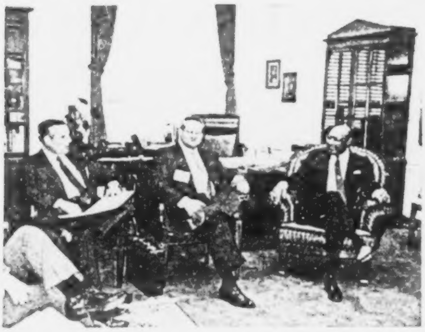
The industry was also the largest employer in the region with 99,903 workers, or one out of every 11 persons employed.

The study was based on the latest available data (1986) covering seven counties: Cuyahoga, Geauga, Lake, Lorain, Medina, Portage and Summit.

While the seven county region lost a net total of 25,000 jobs between 1980 and 1986 (a decline of 2.2 percent), the health services industry gained 19,000 employees.

For example, the health

see Study, next page



GCHA Executive Council President David Plate (left) and St. Luke's Hospital President David Youngdahl (center) discuss Medicare with U.S. Rep. Louis Stokes in Washington, D.C.

Robinson Memorial Hospital President Ralph Kletzien (left) talks with U.S. Rep. Dennis Eckart about the Medicare crisis.

Healthcare Industry Fights Cuts in the Medicare Program

Hospitals, members of Congress, and thousands of other concerned citizens are voicing their objections to plans which will cut the nation's Medicare budget.

Because of the public outcry against Medicare budget reductions, 41 U.S. Senators and 240 U.S. Reps. have cosponsored a resolution to exempt Medicare from cuts in the 1990 budget.

In northeast Ohio, U.S. Representatives Ed Feighan, Mary Rose Oakar, Louis Stokes and James Traficant have cosponsored the resolution.

More than 15,000 northeast Ohioans signed petitions earlier this year which were hand delivered to members of Congress encouraging their support.

According to the General Accounting Office, Medicare payments to hospitals were reduced $17.3 billion between 1981 and 1986.

By not adequately reimbursing hospitals, the government is running the risk of forcing hospitals to reduce quality just to make ends meet. Hospitals have already been forced to close, layoff employees, or cut back on services because of Medicare reductions.

Just to give you an idea of how important the Medicare program is to the financial health of the nation's hospitals, the average U.S. hospital receives about 40 percent of its total patient revenue from Medicare. In northeast Ohio it ranges between 30 percent and 60 percent, depending on the hospital.

A recent public opinion survey (see next page) put the vast majority of northeast Ohioans squarely on the side of hospitals. Nearly 96 percent opposed further cuts in Medicare to balance the federal budget.

Medicare payments to hospitals were reduced $17.3 billion between 1981 and 1986.

In fact, most northeast Ohioans oppose making Medicare patients pay more for their own health care. They do support cutting defense and other programs to balance the federal budget.

The survey also revealed that nearly 66 percent of the respondents said either they or a family member had been a patient in a local hospital within the past two years. Nearly 25 percent said either they or a family member worked in a healthcare job.

Study — continued from previous page

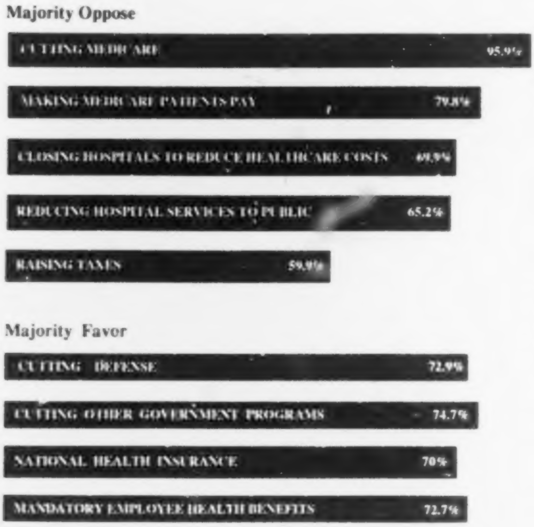
services industry provided 30,000 more jobs than eating and drinking places, a 44 percent differential. Its total payroll exceeded those of the wholesale trade-durable goods and fabricated metal products industries by $684 million and $750 million, respectively.

"This study confirms that our healthcare industry is very important to the economic health of the region," said Hospital Association President C. Wayne Rice.

"It also shows that health care is a growth industry providing numerous economic development opportunities."

Poll: N.E. Ohioans oppose Medicare cuts

The scientific poll surveyed 861 persons in Cuyahoga, Geauga, Lake, Lorain, Medina, Portage and Summit counties. The telephone survey conducted during the third and fourth week of December 1988 by Opinion Centers America, Inc., is accurate within plus-or-minus 3.5 percent.



Henry Manning, President of the MetroHealth System, Roger Wesels, Chairman of the Ohio Hospital Association Board of Trustees, Congresswoman Mary Rose Oakar and Greater Cleveland Hospital Association President C. Wayne Rice, Ph.D., discuss Medicare issues during a Washington, D.C. news conference.

Hospitals Shoulder Uninsured Burden

The number of Greater Clevelanders without any health insurance increased 35.4 percent, from 157,366 to 213,075, between 1980 and 1988. This growing problem is pushing the health-care system to its limits in the amount of uncompensated care which can be provided.

One of the most serious concerns is that these persons generally wait until they are very sick before seeking care. By then, the cost of their care is usually much higher than it would have been if care had been sought earlier.

Area hospitals spent $115 million in 1987 to provide care to those who could not or would not pay. Ultimately, we all pay for uncompensated care, because hospitals are forced to increase their charges to paying patients to make up for the losses from caring for the uninsured and under-insured.

$115 million was spent by area hospitals in 1987 to provide care for those who could not or would not pay.

Legislation in the statehouse—championed by hospitals, the state chamber of commerce, and other concerned groups—is responding to the problem. The legislation would establish several demonstration projects across the state designed to get healthcare benefits to the uninsured "working poor."

A study commissioned by the Association revealed there are about 26,000 employees in the Cleveland area without health insurance, and another nearly 34,000 children under the age of 15 without any health coverage.

Action Taken to Reduce Nursing Shortage

Although the chronic nursing shortage continues across the United States, its severity is not as great in the Greater Cleveland area.

According to a 1988 survey, the vacancy rate for registered nurses in the Greater Cleveland area was 10.5 percent. Nationally, the rate is about 14 percent. These are nursing positions which have been budgeted but remain unfilled.

The vacancy rate for registered nurses in the Greater Cleveland area was 10.5 percent. Nationally, the rate is about 15 percent.

Area hospitals have taken an aggressive approach to the nursing shortage, including funding an innovative program called Nursing Now, an independent program designed to recruit nurses and enhance the image of the profession.

Additionally, the Association initiated the Health Careers Service to address the problems of all health careers in short supply, with a focus on nursing.

The Health Careers Service will work with member hospitals to develop programs which better utilize nursing resources, seek state and federal legislative financial aid help to promote nursing as a profession and to develop affiliations between centers of nursing education and hospitals.

The hospital association is also taking an active role in developing nursing scholarships to draw more students into the area's existing nurse training programs.

New Trauma Care Guidelines Endorsed

Hospitals and physicians across northeast Ohio have for the first time joined together in a new and voluntary effort to save more lives through the treatment of trauma patients.

The Greater Cleveland Hospital Association has endorsed guidelines, developed by the Academy of Medicine of Cleveland, which call for the highest possible standards for trauma care in this area.

The trauma system is essentially a method of getting severe trauma victims to a hospital equipped to provide appropriate care, rather than just transporting them to the nearest hospital.

Trauma—severe injury from automobile crashes, firearms, falls, near-drownings, poisoning, fires and so forth—kills 140,000 to 160,000 Americans each year. Half of all trauma deaths occur in teenagers and young adults (age 13 to 34). Severe trauma cases account for between five and seven percent of all accident victims.

Trauma--severe injury from automobile crashes, firearms, falls, near-drownings, poisoning, fires and so forth--kills 140,000 to 160,000 Americans each year.

Research has shown that regional trauma centers can save lives. A 1985 study of the San Diego County California system, started in 1984, found the death rate from major trauma dropped 55 percent.

The trauma guidelines have also been endorsed by the Northeast Ohio Society of Emergency Physicians.

Your life may have a second chance because of these firsts.
CLEVELAND

The first ad of the New Cleveland Campaign lists the numerous medical achievements in northeast Ohio.

Area Hospitals Gain National Attention

Northeast Ohio hospitals will get a boost in a national advertising campaign now underway and sponsored by the New Cleveland Campaign. The non-profit organization, whose task is to promote the Cleveland area, ran the first in a series of ads in *The Wall Street Journal*, *Business Week*, *Forbes*, *The Plain Dealer* and trade magazines.

The ads are based in part on studies, including one conducted for the Greater Cleveland Hospital Association, which point to the significance of health care in the region.

The first ad features medical "firsts" that happened in northeast Ohio. Headlined: "Your life may have a second chance because of these firsts," the ad is a list of achievements. Included are: the first use of x-rays in the country; development of kidney dialysis; development of coronary bypass surgery; the first public hospital system; and the development of amniocentesis.

Caring for the Poor: a Growing Problem

The growing number of poor in Ohio who seek medical care through the Medicaid program is continuing to strain this healthcare safety net. According to the Department of Human Services, the number of participants in the Medicaid program increased 13 percent during 1988 from 505,386 to 571,989.

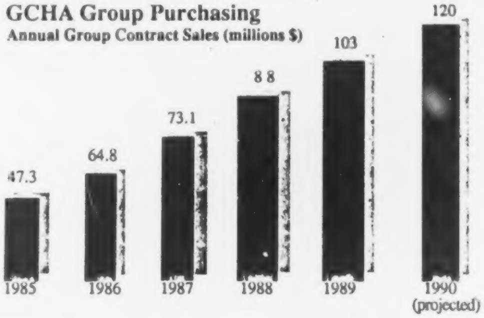
Projecting a $155 million shortfall in the state's Medicaid budget during fiscal year 1989, the state legislature approved a supplemental budget package to avert a Medicaid budget crisis.

Hospital administrators and the Greater Cleveland Hospital Association began an aggressive campaign in 1988 to educate state legislators about the seriousness of the Medicaid problem. House and Senate members from northeast Ohio worked together to appropriate emergency funding. House Speaker Vern Riffe was particularly sensitive to the funding crisis and took swift action.

Only 62 percent of those in poverty are covered by Ohio's Medicaid program.

Providing adequate government funding to care for the truly poor affects all of society, not just the poor and healthcare providers. Just as with the nation's Medicare program for the elderly, less than adequate funding for Medicaid requires healthcare providers to seek higher payments from other paying patients to make up any shortfalls.

Only 62 percent of the persons at or below the poverty level are actually covered by Ohio's Medicaid program. This leaves 570,000 persons in Ohio without the resources to pay for healthcare services.



GCHA Group Purchasing

Annual Group Contract Sales (millions $)

Group Purchasing Saves $40 Million

One of the most important roles played by the hospital association in helping to keep consumer costs down is its group purchasing program.

The group purchasing program saves an estimated $40 million a year for member hospitals which can pass the savings along to patients.

The group purchasing program began in 1918 to address member hospitals' needs for more stringent purchasing methods. From the beginning, the program's key objective has been to help members purchase supplies at the lowest possible cost.

The program has grown substantially over the past few years, and is expected to reach $120 million in sales by next year.

During this time, many changes have taken place in health care that have focused increasing attention on the need for group purchasing.

In order to meet these new challenges, the group purchasing program is segmented into four primary program areas: general purchasing, dietary, laboratory and pharmacy

As you can see from the accompanying graph, the program's volume growth has soared during the 1980's and continued growth is expected into the next decade. Volume saving is only a portion of the overall savings that the program offers.

When utilized effectively, group purchasing performs the administrative function of shopping, preparing and evaluating proposals, negotiating, and monitoring overall quality — all adding up to savings of time and money.

The program has grown substantially over the past few years, and is expected to reach $120 million in sales next year.

At the beginning of the year, the group purchasing program was reorganized into two separate GCHA affiliates in a renewed effort to provide cost-effective services. Central Hospital Services is the management services program for non-profit hospitals and HealthComp provides similar services to organizations other than hospitals.

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Chairman OAKAR. Thank you very much, Mr. Gillespie.

Mr. Werner, of the Interchurch Council. Thank you for being here.

Mr. LANGE. Thank you.

Chairman OAKAR. Werner Lange, I'm sorry, Werner.

Mr. LANGE. That's quite all right. Thank you very much, Congresswoman.

Chairman OAKAR. Thank you, Werner, for being here.

Mr. LANGE. I guess my role is to provide the benediction testimony.

Chairman OAKAR. No, you are not—we've got four more people.

Mr. LANGE. I see, well, good, excellent.

Chairman OAKAR. We have some very important people who are still going to testify.

STATEMENT OF WERNER LANGE, Ph.D., REPRESENTING THE INTERCHURCH COUNCIL OF GREATER CLEVELAND

Mr. LANGE. The Interchurch Council represents some 700 area Protestant churches, and I'm giving testimony as a community issues specialist for that organization.

Two days ago, we, as a Nation, celebrated the empowerment of some self-evident truths, the truth that we are all created equal and endowed with certain basic human rights.

However, I would suggest our current health care system helps guarantee that we are not all born equal, that we do not all die equal, and that our bodies and our health are not all treated equally between womb and the tomb.

This is because the ability to pay and not need seems to be the primary determinant of a patient's quantity and quality of health care, and this contradicts, I would suggest, much of what we just celebrated 2 days ago. Life, liberty, and the pursuit of happiness are exceedingly difficult for those not fully able to fully pay their medical expenses, and this is unfair.

Health care is a right to be enjoyed by all, not a privilege reserved for the few, and all of us who are privileged to be Americans should also be afforded free basic health care as a basic national birth right, birth rights, I hope, which will become a national policy.

The current national policy on health appears terribly muddled for many of us outside of the medical community. Only limited, not comprehensive, health care is provided for only some, and not all citizens of our country. It's almost as if the policymakers assume that certain categories of illness are endurable and certain categories of Americans are disposable.

This prejudiced mindset, I suggest, one that regards some Americans as more worthy of good health care than others, is at the root of the health care crisis we face. Why else is it that our Nation and the Republic of South Africa are the only two industrialized nations on Earth without a comprehensive health care system for all citizens?

I'm sure all of us would agree, certainly members of the Commission, that there are no disposable Americans and, therefore, I would suggest that there should be not a single citizen without affordable health care services when needed.

However, we know that there are 37, perhaps more, million Americans without any health insurance whatsoever, 1½ million of them live in Ohio, the heart of the industrialized America, and tens of thousands of Americans without health insurance reside right here in Cuyahoga County, many of them within the shadow of one of the world's finest medical institutions, the Cleveland Clinic, which is more accessible to rich foreigners than it is to poor Clevelanders.

Chairman OAKAR. Well, you know, I'm going to take issue with that, but keep going.

Mr. LANGE. OK. Well——

Chairman OAKAR. Because, they serve a lot of poor people, but go ahead.

Mr. LANGE [continuing]. Let me try to back up my statement with a rather——

Chairman OAKAR. No, no, just keep going.

Mr. LANGE [continuing]. Prominent source. There's a story in the Bible about a rich man who lived in luxury while a poor man, Lazarus, lay at his gate full of sores. The poor man's health was not cared for and he died, and was, as the Apostle Luke describes it, "* * * carried by angels into Abraham's bosom."

The fate of the uncaring rich man, however, was quite different. In fact, his fate is the only description Christ gives in the entire Bible of hell.

We should make no mistake about the issue that we confront. This is a moral issue as much as it is a financial, a political, or a medical one. Our rich medical facilities simply have no moral right to deny basic health care to the poor and uninsured lying at their gates. To do so violates the law of Christ, as we understand it.

Unfortunately, denying the uninsured health care does not currently violate the law of the land. That's why the law needs to be changed.

We at the Interchurch Council strongly support national health care, and we have called upon our constituency to urge passage of national health care legislation.

We have also strongly endorsed the Universal Health Insurance for Ohio Act, and have circulated petitions on its behalf.

Among the many petition signatures that we have gained, were ones from clients of hunger centers, hundreds of clients of our hunger centers signed these petitions calling for an Ohio-based health insurance plan. These are among the poorest residents of this community. To qualify for food, incidentally, from these hunger centers, you cannot earn more as a family of 3 of $685. This approximates the minimum standard of needed income in the State, but it's too high for Medicaid coverage.

A family with an income below the State's minimum standard of need qualifies for free food, but according to current policy this poor family is too rich for free health care. I ask, is health care for the sick any less important than food for the hungry? And, how can policymakers rationally, let alone morally, make distinctions between certain families who deserve and get health care and those who do not, between employees who get health care benefits and those who do not, between needy senior citizens and disabled citizens who qualify for long-term care and those who do not?

The fact is that there is no morality nor rationality in the denial of basic health care services to anyone who needs it, regardless of age, income, race, employment status, or the insurance company that happens to cover them.

There's a case in point that I'd like to draw your attention to of the irrationality that could be fixed very easily without making basic changes. The DPT [diphtheria, pertussis, tetanus] Program within the county, last year the Cuyahoga County Board of Health arbitrarily suspended all free DPT inoculations, claiming that there was insufficient insurance to cover liabilities. Staff nurses of their board of health objected to the cessation policy. The director of Ohio's Department of Health, as well as Ohio's Chief of the Bureau of Preventive Medicine, demanded resumption of these free DPT shots in Cuyahoga County, and we at the Interchurch Council lent our voice, but to no avail. Five board members stubbornly refused to provide free, State-mandated DPT shots throughout the county of Cuyahoga, making it the only local board in the entire Nation which denied children State-mandated health care to prevent a highly communicable disease. In other words, the financial status of five men seemed to have taken precedence over the health status of tens of thousands of Cleveland area children. This is a bureaucratic flaw. Local boards of health should not have the power to defy State or Federal mandates. They should not be fully autonomous units, but an integral part of a rationally connected health care system with Federal, State, and local divisions.

Just for the record, I'd like to share a letter from Pat Morgan, a staff nurse of the Cuyahoga County Board of Health, regarding these DPT shots and their clientele. "The profile of our clients is not that of poverty level population. Most of our clients are employed, modest income, single or two-parent families. In recent years, many are temporarily unemployed. The common denominator is that they do not meet the financial criteria to obtain immunizations. The State of Ohio has energetically pursued the goal of total eradication of immunization preventable diseases, but the status of the DPT Program at Cuyahoga County gives us great concern."

Another example has to do with the——

Chairman OAKAR. I'm going to have to ask you just to summarize if you could, because we have four other witnesses.

Mr. LANGE. OK.

The last point that I'd like to make involves finances.

Chairman OAKAR. And, I happen to agree with you on that point.

Mr. LANGE. Right, that was a serious problem.

I'd like to make this point because none of the previous members of the panels have focused upon it, dealing with financing a national health care system. We are still the richest country on Earth, and we can afford, if we wanted, a comprehensive health care service. In fact, we can't afford to enter the next century without one. We can, however, afford to enter the next century without nuclear weapons, without chemical weapons, without exotic Star Wars weapons, and with hundreds of thousands of American soldiers stationed in Europe in lands that can adequately be defended by indigenous troops. This is a source of a large sum of funding.

This is 1989 not 1939, the threat of war diminishes every day, and a new thinking has taken hold in the East, as well as many parts of the West. I encourage members of this commission to echo this new thinking and help beat our unneeded swords into sorely needed services for the health of us all.

[The prepared statement of Mr. Lange follows:]

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STATEMENT TO THE
Bipartisan Congressional Commission on Comprehensive Health Care
July 6 1989
Cleveland, Ohio

by

Werner Lange, PhD
Community Issues Specialist for the
Interchurch Council of Greater Cleveland

Two day ago we, as a nation, celebrated the empowerment of a few self-evident truths: the truth that we are all created equal and that we are all endowed with the same basic human rights.

However, our current health care system helps guarantee that we are not all born equal; that we do not all die equal; and that our bodies and health are not treated equally from womb to tomb. This is because ability to pay, not need, is the primary determinant of a patient's health care. This contradicts much of what we celebrated on the Fourth of July. Life, liberty and pursuit of happiness are not fully achievable for those not able to fully pay their medical expenses. This is unfair, and should be changed immediately and fundamentally. Health care is a right to be enjoyed by all, not a privilege reserved for the few. All those privileged to be Americans should also be afforded free basic health care as a national birthright, one that should become national policy.

Current national policy on health is terribly muddled. Only limited,- not comprehensive, health care is provided only some, not all, Americans. It is as if policy-makers assume certain categories of illness are endurable, and certain categories of Americans are disposable. This prejudiced mindset, one which regards some Americans are more worthy of good health care than others, is, I believe, at the root of the health care crisis we face. Why else would we and the Republic of South

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be the only two industrialized nations on earth without a comprehensive health care system for all citizens? There are, as I am sure Commission members agree, no disposable Americans. Therefore there should not be a single citizen without affordable health care services when needed.

However, 40 million American have no health insurance whatever. 1.5 million of the live in Ohio, the heart of deindustrialized America. Tens of thousands of Americans without health insurance reside in Cuyahoga County, many of them within the shadow of one of the world's finest medical facilities, the Cleveland Clinic, which is more accessible to rich foreigners than to poor Clevelanders.

There's a story in the Bible about a rich man who lived in luxury while a poor man, Lazarus, lay at his gate sick and full of sores. The poor man's health was not care for; he died and was, as Luke tells us, "carried by angels into Abraham's bosom". The fate of the uncaring rich man was quite different. In fact, his fate is the only description Christ gives in the entire Bible of hell.

We should make no mistake about the issue we confront. This is a moral issue as much as it is a financial, medical or political one. Our rich medical facilities have no moral right to deny basic health care to the poor and uninsured at their gate. To do so violates the Law of Christ. Unfortunately, denying the uninsured health care does not violate the law of the land. That's why the law needs to be changed and brought into harmony with justice and morality.

The Interchurch Council of Greater Cleveland supports national health care, and has called upon our constituency to urge passage of national health care legislation. We have also endorsed the Universal Health Insurance for Ohio Act, and have circulated petitions calling for its enactment. Among the many petition signatories are 255 clients of Hunger Centers operated by the Interchurch Council. These are among the poorest residents of this community; a family of three cannot have a monthly income over $685 and still qualify for food from a Hunger Center. This amount approximates the minimum standard of needed income in this state. But it is too high for Medicaid coverage. A family with an income below the state's minimum standard of need qualifies for free food, but according to current welfare policy, this poor family is too rich for free health care. Is not health care for the sick as important as food for the hungry?

How can policy-makers rationally, let alone morally, make distinctions between poor families who deserve and get health care and those who do not? Between employees who get health care benefits and those who do not? Between needy senior citizens and disabled citizens who qualify for long-term care and those who do not? The fact is that there is no morality or rationality in denial of basic health care services to anyone who needs it, regardless of age, income, race, employment status or insurance company.

The DPT program is a case in point. Last year, the Cuyahoga County Board of Health arbitrarily suspended all free DPT innoculations, ostensibly because of insufficient insurance from liability suits. Staff nurses of the Board of Health objected to the cessation policy; the Director of Ohio's Department of Health as well as the Chief fo the Bureau of Preventive Medicine demanded resumption of free DPT shots in Cuyahoga County; and we at the Interchurch Council added our protest and concerns. But to no avail. Five Board members stubbornly refused to provide free, state-mandated DPT shots through the Cuyahoga County Board of Health, making it the only local Board in the entire nation which denied children state-mandated health care to prevent highly communicable disease. The financial status of five men took precedence over the health status of tens of thousands of Cleveland area children. In other words, misplaced priorities and an irrational bureaucratic structure allowed for wholesale elimination of a basic health service to area children. Local Boards of Health should not have the power to defy state or federal mandates. They should not be autonomous units, but an integral part of a rationally connected health care system with federal, state and local divisions.

Just for the record, I'd like to share a letter to me from Pat Morgan, a staff nurse of the Cuyahoga County Board of Health, regarding the DPT program and its clientele:

> "...the profile of our clients is not that of the poverty level population. Most are employed, modest income, single or two-parent families. In recent years, more are recently and/or temporarily unemployed. The common denominator is that they do not meet the financial or geographical criteria to obtain immunizations from any other publicly funded source, but are unable to afford this care in the private sector. That State of Ohio has energetically

pursued the goal of total eradication of immunization-preventable diseases: diptheria, tetanus, whooping cough, polio, measles, mumps and rubella. One un-immunized or under-immunized child represents a risk factor which extends beyond geographic and age boundaries. The current status of the immunization program in the Cuyahoga County Board of Health jurisdication, is indeed of grave concern..."

Another example of current irrationality in provision of health care was revealed during the bitter recent strike at MetroHealth in Cleveland. Despite a total work stoppage by thousands of service and other employees at this publicly subsidized facility, hospital administrators continued nearly all operations and consistently claimed no dimunition in quality of care provided. Community leaders asked the Ohio Department of Health for an investigation, but were told it lacked jurisdiction over MetroHealth. It referred our request to the Health Care Financing Administration, a federal agency, which in turn requested the Ohio Department of Health to conduct an investigation. This procedure seems unnecessarily confusing and time-consuming. It seems more rational in this case to provide state health departments with jurisdictional authority to investigate compliance with health care service requirements.

The last point I'd like to make involves finances. We are still the richest country on earth. We can afford a comprehensive health service for all. In fact, we cannot afford to enter the 21st century without one. However, we can afford to enter the next century without nuclear weapons; without chemical weapons; without bacteriological weapons; without Star Wars weaponry; and without hundreds of thousands of American soldiers stationed in Europe and other lands adequately defended by indigenous troops. This is where a great source of public funds lies and continues to be wasted, massively. 1989 is not 1939. The threat of war diminishes each day. A new thinking has taken hold in many parts of the East and West, one which makes massive bilateral reductions in military expenditures not only possible, but necessary. I encourage members of this Commission to echo this new thinking, and help beat our unneeded swords into sorely needed services for the health of all.

Chairman **Oakar**. Thank you. Mr. Lange, thank you very much.

Let me just ask one quick question of whoever wants to answer. I have been concerned over the years with the fact that licensed practitioners are not directly reimbursed for certain services that are relatively easy to do. I really feel that if we had a team approach to some of our problems, we would, perhaps, save some money and give a complement of services.

Does anyone want to comment on that? I've introduced some legislation over the years for long-term care that encourages doctors, nurses, and other health specialists and homemaker service-type people, et cetera, to work together as a team.

Why do I get such opposition on that from some of my friends who are doctors? Why can't we work as a team and look at the kinds of avenues of care that would really provide the congregate services that we've heard mentioned today?

Doctor, would you like to comment?

Dr. **Castele**. I would very much, thank you. First of all, I absolutely agree with you that we need to use paramedical people to help us as much as seems reasonable. We do need more home health care services, as was brought up by the long-term care people. We do need to have day care centers, and we do need to have people that provide all those services compensated appropriately.

One of the problems is that the laws that we currently have seem to do this in the reverse. In some cases in Ohio, there actually is a higher degree of compensation for a nurse to make a home visit than for a physician to make the very same home visit. I think the whole area does need to be readdressed and looked at again, but I'm with you on that.

Chairman **Oakar**. Doctor?

Dr. **Frisof**. Yes. I'd like to talk to that briefly, because I think that the only real answer is a single comprehensive system. I mean, unfortunately, the choice that we have is not only Star Wars versus home nursing, it's also MRI's versus home nursing. And, the only way to have a rational debate among health care priorities and practice techniques is through a single system.

Thank you.

Chairman **Oakar**. Thank you very much.

Dr. **Laing**. Congresswoman, I'd like to just add one other element of that. Under the Hospice Program we do use multidisciplinary services, that include homemakers, home health aides, social workers, nursing staff, physician, and it can be very cost effective. I just wanted to make the point that it is possible to deliver those services in the community and keep a cost-effective means at the same time.

Chairman **Oakar**. Ed, did you want to ask a quick question here?

Mr. **Howard**. One quick question for Dr. Binstock, if I can.

Chairman **Oakar**. OK.

Mr. **Howard**. You talk about financing of a system of long-term care that left assets in tact, and asked us to raise some questions about that.

If the financing system included a substantial tax on estates somewhere under the current threshold of $600,000, would that address some of the moral questions that you are raising?

Dr. Binstock. I don't think the financing mechanism is the issue. You can tax estates, you can tax value-added in transactions, you can tax anything you want.

I think the first question is, as a matter of public policy, is it important to provide public long-term care insurance to everyone, no matter what their wealth in terms of assets and income, is it universal coverage on that?

It's much the same issue as Dr. Frisof raised, is health a social good? Is long-term care a different kind of health care or the same kind of health care, a social good that should be entitled to everyone?

I don't think that issue has been examined. My own view is that health care is different from all the other goods and services in this country, and taking the 20 seconds you've opened up, or 2 minutes, I can't understand why in this country we regulate the rates on telephones, electricity, and all sorts of "businesses" affected with the public interest, but the health care sector or industry is one of the most profitable, unregulated sectors in this country.

Under the doctrine of businesses affected with the public interest, I can't think of one more affected than health care.

Chairman Oakar. Well, thank you all very, very much for your important testimony. I don't think we're going to be able to address this issue unless we have a team approach to the problem.

You know, honestly, we just can't afford to have different groups opposing each other or going it alone and so on, because we'll never get anything done. That's why I wanted to have a cross section of opinions here.

I think everyone feels strongly about providing access to health care for every American, and at least we can go forward on that. So, thank you very much.

We're going to finish with, among the most interesting people, Ms. Judith Peters, who is the vice president for development—oh, Teresa Saxton is representing the Visiting Nurses Association; Mr. Ken Campbell of the Ohio Developmental Disabilities Planning Council, director of the Health Insurance Task Force; Ms. Janet Auburn, executive director of North Coast Health Ministry; and Ms. Sharen Eckert of the Ohio Long-Term Care Action Network of the Cleveland chapter of Alzheimer's Disease and Related Disorders.

And, Alma is here, who is going to have a few words to say about independent living.

OK. We have gone a little longer than we thought, but I think it's important, so we'll move on and try to finish up here. If I can have your attention, we will start. OK?

I want to, while we are getting situated, thank the different organizations who were helpful in getting the variety of witnesses that we have. You've just been terrific, and I am really proud of the area I represent. I tell you, despite all the criticism, and we have a lot of things that we have to make better, but we have some wonderful people in our area, and you were very helpful. I am deeply grateful.

All right. Ms. Peters, we are going to start with you, Judy. Thank you very much for being here.

Ms. **Saxton**. Excuse me, Congresswoman Oakar, I am Teresa Saxton.

Chairman **Oakar**. OK. Every year I introduce a resolution related to visiting nurses, and I'm all for you. So, you are just great men and women, so I'm sorry I made that mistake.

Ms. **Saxton**. That's all right. I'm here on behalf of Judy Peters, who is ill today.

Chairman **Oakar**. OK.

Ms. **Saxton**. And, I think you have her written testimony. I think in the interest of time, and the fact that some of the previous panels have more than adequately addressed some of the issues that she's included, I'd like to just read the last—the summarized version of her testimony.

Chairman **Oakar**. And, we'll put your entire statement in the record.

STATEMENT OF TERESA SAXTON, REPRESENTING VISITING NURSES ASSOCIATION OF CLEVELAND ON BEHALF OF JUDITH PETERS, VICE PRESIDENT FOR DEVELOPMENT, VISITING NURSES ASSOCIATION

Ms. **Saxton**. Thank you.

I am here representing the 87-year-old community agency, the Visiting Nurses Association [VNA] of Cleveland. We annually deliver home care services to thousands of elderly and disabled greater Clevelanders.

Last year, we provided some 96,000 home care visits in the greater Cleveland area. Some 14,000 of these visits were made to patients who otherwise would have been unable to afford such care. VNA services range from basic home care to highly specialized and technical therapy.

As the vice president of the Visiting Nurses Association, we feel the need to address some of the shortcomings we find in the current health care delivery system.

Over the course of the next year, 1.5 million Americans will suffer heart attacks, 500,000 will endure the devastating effects of a stroke, 3 million will have Alzheimer's disease, 5 million will struggle to overcome cancer, and 10 million children will be the victims of chronic health problems.

The question of who is to pay for their long-term care needs is reaching crisis proportions in our society. Estimates are that the national health care bill in 1990 will exceed $650 billion, yet, 37 million Americans still lack health care insurance. According to the Health Care Financing Administration, Medicaid accounts for 1.4 percent of the long-term health care expenses. Medicare pays only 1.6 percent of the bill, and private insurance pays less than 1 percent.

Faced with paying over 51 percent of costly medical bills, many patients, understandably so, receive inadequate health services upon discharge from hospital care.

These grim statistics reflect a general U.S. failure to provide adequate social and fiscal response to growing long-term health care needs to our disabled and elderly.

In the upcoming congressional deliberations, we at VNA ask you to keep in mind three major points. The scope of home-based services covered by any long-term care legislation must include not only health-related services, but also homemaker and personal care services, adult day care and respite care. Second, patient case management, including eligibility assessment and patient care plans, should not be limited to State-run agencies, but be able to be provided by private, nonprofit agencies such as VNA. Third, Medicare copayments for infirmed and home-bound seniors should not be increased. Such patients cannot be financially burdened any further. The Federal Government must allocate tax revenues so as to continue to provide a proportionate share of long-term care costs to elderly, disabled, and chronically ill children who cannot adequately perform basic activities of daily living. This is especially true in the face of expanded technological applications for specialty and high-tech home services, and the increasing cost of specialized medications and treatments.

Thank you.

[The prepared statement of Ms. Peters follows:]

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Cleveland, Ohio 44114
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TESTIMONY BEFORE U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

Congressman Claude Pepper was indeed a great friend to the elderly of this country. His legacy challenges us to speak out on behalf of our older friends and neighbors--to be advocates of those who lack the ability to care for themselves.

I have an image of Congressman Pepper going up to heaven and being met by St. Peter. St. Peter took the congressman by the elbow and started leading him up to the throne of God. As they walked along, Claude looked at the people gathered around the throne and was surprised by what we saw. To the left of the throne were the bureaucrats. To the right of the throne were the lobbyists and other politicos. And there, right smack in front of the throne, were his many former colleagues from the congress and senate.

Old Claude stopped in his tracks and turned to St. Peter in his booming voice, as only Claude could, bellowing: "Where are all the ordinary people?" And St. Peter whispered "Shhh!" and pointed to a hill way off in the distance. And sure enough, there they were--the people on whose behalf the good congressman had advocated for many years...the elderly, the chronically ill, those suffering from diminished capacity. And puzzled by all this, Claude bellowed again: "What are they doing so far away over there?" St. Peter said "Shhh!" and looking around to make sure no one was listening, he whispered: "They're the only ones He can trust that far out of his sight."

My friends, I welcome this opportunity to speak on behalf of those "ordinary people" who were so dear to Claude Pepper. I am here representing an 87 year old community agency--the Visiting Nurse Association of Cleveland--which annually delivers home health care services to thousands of elderly and disabled Greater Clevelanders. Last year, we provided over 96,000 home care visits in the Greater Cleveland area. Some 14,000 of these visits were made to patients who otherwise would have been unable to afford such care. VNA's nursing services ranged from basic home care to highly-specialized and technical therapies. As Vice President of the Visiting Nurse Association, I feel the need to address some of the shortcomings we find in the current health care delivery system.

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Over the course of the next year, 1.5 million Americans will suffer heart attacks, and 500,000 will endure the devastating effects of a stroke. Three million will have Alzheimer's disease, 5 million will struggle to overcome cancer, and 10 million children will be the victims of chronic health problems. The question of who is to pay for their long-term health care needs is reaching crisis proportion in our society.

Estimates are that the nation's health care bill in 1990 will exceed $650 billion, yet 37 million Americans lack health insurance. According to the Health Care Financing Administration, Medicaid accounts for 41.4% of long-term health care expenses. Medicare pays only 1.6% of the bill, and private insurance pays less than 1%. Faced with paying over 51% of costly medical bills, many patients (understandably so) receive inadequate health services upon discharge from hospital care.

What do you do when you cannot care for yourself, but Medicare and private insurance fall short? What do you do when you can't feed yourself and you're forced to lie in bed unattended for days at a time? Where do you turn when you develop bedsores from remaining too long in one position? Who is there to hear your unspoken cry when a stroke-initiated impairment prevents you from calling out for help? Well, you can always appeal Medicare's bureaucratic brand of "ineligible." And the appeal might succeed; and Medicare just might help--but if, and only if, you sell your home and liquidate your assets! Who needs such help!

In 1988, long-term health care legislation was offered in both houses of congress. These bills were designed to provide Medicare funding for skilled nursing care, home care, day care, and respite care programs. Cost estimates of the proposed legislation ranged from $22 billion to $63 billion, but none of these bills emerged from either house of Congress.

These grim statistics reflect a general U.S. failure to provide adequate social and fiscal response to the growing long-term health care needs to our disabled and elderly. How are we as a society to cope with such ethical and economic issues? In the upcoming congressional deliberations, I ask you to keep in mind three major points:

- The scope of home-based services covered by any long term care legislation must include not only health-related services, but also homemaker-personal care services, adult day care, and respite care.

- Patient case management, including eligibility assessment and patient care plans, should not be limited to state-run agencies but be provided by private nonprofit agencies such as the VNA.

- Medicare co-payments for infirm and homebound seniors should not be increased. Such patients cannot be financially burdened any further. The Federal government must allocate tax revenues so as to continue to provide a proportionate share of long term care costs for elderly, disabled, and chronically-ill children who cannot adequately perform basic activities of daily living. This is especially true in the face of expanding technological applications for specialty and high-tech home services and the increasing costs of specialized medications and treatments.

A CBS newsman once asked Senator Pepper how he would like to be remembered. He answered: "Claude Pepper loved God and the people, and tried to serve both." The passage of a long term care bill during this congressional session is a high priority. There would be no better way to memorialize Senator Pepper than to push through such legislation.

Chairman OAKAR. Thank you very much, Ms. Saxton.
Janet?

STATEMENT OF JANET L. AUBURN, EXECUTIVE DIRECTOR, NORTH COAST HEALTH MINISTRY

Ms. AUBURN. Thank you for the opportunity to be here today and share with you some of the things we are doing in the area of the uninsured.

Chairman OAKAR. Could you pull that up a little closer?

Ms. AUBURN. A little more, OK.

Chairman OAKAR. You are the executive director of the North Coast Health Ministry.

Ms. AUBURN. Right.

Chairman OAKAR. All right.

Ms. AUBURN. Our ministry has been dedicated to providing medical care for uninsured children and adults whose family income is too great for Medicaid, yet, way too low to afford health insurance.

The mission of our organization is to provide comprehensive medical care to individuals living in the western suburbs of Cleveland with a family income that is below 150 percent of the Federal Government's poverty level. That's approximately $15,000 for a family of four.

We fulfill our mission by providing medical services, including diagnosis, treatment, and referral. We began as a vision of one physician who believed that God has blessed his life and called him to give his gifts and talents back to those less fortunate. In 1987, we incorporated as a 501(c)(3) and a vision became reality.

Then, we faced another insurance problem. It took a full 11 months to obtain liability insurance for our board, and it cost us 80 percent of the seed money given by area churches.

The second year of operation, the board of trustees decided not to renew the insurance policy, convinced it was not good stewardship of our limited funds.

Open only 9 hours a week, we have had more than 1,000 patient visits and provided care valued at more than $500,000. Churches and concerned individuals donate necessary funds. Physicians, nurses, and clerical staff donate time every week to see patients. Hospitals provide space, equipment, ancillary testing, and hospitalization. Corporations donate office equipment, supplies, and furnishings. Thus, we've been able to provide more than a half a million dollars worth of medical care on a budget under $25,000.

Many of our patients require care and services that currently extend beyond our clinic scope. More than 75 physician specialists provide followup care in their private practice at no cost to our patients. Both Lakewood Hospital and St. John's and West Shore Hospital donate continued services prescribed by our physicians. Health Campus Pharmacy and Discount Drug Mart fill prescriptions at reduced cost.

We are a unique organization. We have managed to pull together concerned sectors of the community, and through the cooperation of many, where each share a part of the problem, no one is overburdened.

Our accomplishments are significant, but they do not begin to address the overwhelming need. We are serving only 2.1 percent of this population in the western suburbs. Our statistics show the majority are single mothers with children and young single adults.

The problem of 37 million Americans without health insurance must be addressed on a much broader scale. I would like to challenge the Commission to be bold and creative in its approach to solutions, and to try to be open to creating a system with a team approach where all share the burden of the insurance problem.

We have heard today that small business is concerned, physicians are concerned, hospitals are concerned, and even uninsured individuals are concerned and willing to pay.

Working together, through dialog, hearings such as this commission provided today, and legislation, basic health care can become the right of all citizens.

Thank you for the opportunity to give testimony, and I, for one, will be eagerly awaiting your recommendations.

[The prepared statement of Ms. Auburn follows:]

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TESTIMONY PROVIDED TO THE COMMISSION ON COMPREHENSIVE HEALTH CARE

by JAN AUBURN
Executive Director
North Coast Health Ministry

July 6, 1989

15644 Madison Avenue, Suite # 204, Lakewood, OH 44107
216/228-7878

North
Coast
Health
Ministry
NCHM

Jan Auburn, 228-7878

The Guilliani's, a family of four, highlighted in the December 27th Plain Dealer article entitled "Caring For The New Poor", came to Lakewood from Connecticutt to find an affordable home. In their early 20's, with two young children, including a son with Down's Syndrome, both parents work, have no medical benefits and cannot afford $400.00 per month for medical insurance. The facts are hard to accept. There are more than 17,000 residents in the western suburbs of Cleveland just like the Guilliani family.

Our Ministry has been dedicated to providing medical care for uninsured children and adults whose family income is too great for Medicaid, yet way too low to afford health insurance. The mission of our organization is to provide comprehensive medical care to individuals living in the western suburbs of Cleveland with a family income below 150% of the federal government's poverty level (currently $15,090 for a family of four). We fulfill this mission by providing medical services including diagnosis, treatment and referral.

We began as the vision of one physician who believed God had blessed his life and called him to give his gifts and talents back to those less fortunate. In 1987, we incorporated as a 501(c)(3) and a vision became reality. It took 11 months to obtain liability insurance and it cost 80% of the seed money given by area churches. The second year of operation, the Board of Trustees decided not to renew the insurance policy, convinced it was not good stewardship of our limited funds.

We have had more than 1000 patients visits and provided care valued at more than $500,000. Churches and concerned individuals donate the necessary funds; physicians, nurses, and clerical staff donate time every week to see patients; hospitals provide space, equipment, ancillary testing and hospitalization; corporations donate office equipment, supplies, and furnishings. Thus, we have been able to provide more than a half million dollars worth of medical care on a budget under $25,000.

15644 Madison Avenue, Suite# 204, Lakewood, OH 44107

Many patients require care and services that currently extend beyond our clinics' scope. More than 75 physician specialists provide follow up care. Both Lakewood Hospital and St. John & WestShore Hospital donate continued services prescribed by our physicians. Health Campus Pharmacy and Discount Drug Mart fill prescriptions at reduced cost.

Reaching our target population has not been easy. The "new working poor" do not live in well-defined communities, they are proud and very reluctant to use a charity service. Most do not have any preventive care and wait until medical problems are emergencies, then use hospital emergency rooms. Very expensive care! Obtaining some medical coverage becomes the deciding factor in accepting jobs or staying on welfare and impacts most every other family decision.

Our accomplishments are significant, but do not begin to address the overwhelming need. We are serving only 2.1% of this population in western Cleveland. Our statistics show the majority are single mothers with children and young single adults. The problem of 37 million Americans without health insurance must be addressed on a much broader scale. Working together, through dialogue and legislation, basic health care must become the right of all citizens, not the priviledge of those who can afford to pay.

Jean Auburn

Chairman **Oakar**. Thank you.

And thank you, Sharen, for all the help you've given us——

Ms. **Eckert**. Thank you.

Chairman **Oakar** [continuing]. In the last week or so in getting witnesses and so on.

STATEMENT OF SHAREN ECKERT, REPRESENTING OHIO LONG-TERM CARE ACTION NETWORK

Ms. **Eckert**. OK. Thank you for the opportunity to testify. You mentioned you were proud of our community. I think we are proud of Mary Rose, and having the Pepper Commission come to town, this is a real opportunity.

It's interesting that we're addressing long-term care as one of the issues at a long-term hearing. This has definitely been a marathon, and some of you folks that have been here since the morning know a little bit about what it is like persevering in terms of long-term care.

I'm here as a representative of the Ohio Long-Term Care Action Network, and I have a personal, professional, and community interest in long-term care.

My personal interest stems from the fact that my father and his identical twin brother both died last year after battling Alzheimer's disease for about 20 years. They both retired early, my uncle at only 55, and my father at age 60, because each knew that he was already too impaired to do his job effectively.

In the mid-1960's, Clayton and Clair were both diagnosed as having Alzheimer's disease, and at age 75, last year, 4 months apart to the day, these twin brothers died with this devastating disease.

For all but the last few of these 20 years, Clayton and Clair were cared for in their homes by their wives. As you know, long-term care is not an individual problem, it's a family problem. I relocated, 10 years ago, as many families do, from California to Cleveland, to help share the care of my father.

An entire family must martial its reserves to begin to provide care over the 5, 10, 15, and even 20 years that's required.

Professionally, I am currently the executive director of the Cleveland chapter of the Alzheimer's Disease and Related Disorders Association. The Alzheimer's association sees the availability of long-term care services as one of its primary public policy agendas, probably second only to increased research to eliminate this disease.

In our area of northeast Ohio, there are an estimated 40,000 to 50,000 people with Alzheimer's disease, and nationally, there's about 4 million people that are estimated to have Alzheimer's disease. In most cases, a diagnosis of Alzheimer's disease ensures that the afflicted individual and his or her family will be involved in long-term care. The operative words are long-term care. Alzheimer's caregiving involves 36-hour days, stretching into the future a decade or more.

In terms of my community interest in long-term care, I chair the Advocacy Network, which is the Public Policy Committee of the Western Reserve Area Agency on Aging. I'm also a member of the

Ohio Long-Term Action Network. This is a statewide coalition of senior citizen, church, union, advocacy, and professional organizations.

The Ohio network works closely with the national Long-Term Care Campaign, which is a coalition of almost 130 organizations. This national effort demonstrates the widespread public interest in long-term care. The Long-Term Care Campaign is the largest coalition of organizations formed around a single issue since civil rights. I think that demonstrates that our country is really ready to address this issue as a community.

The Ohio Long-Term Care Action Network is a coalition dedicated to enacting comprehensive legislation to protect American families against the devastating costs of long-term care. Its very membership reflects the diversity of people impacted by long-term care, and although it's certainly of a concern to Alzheimer's families, who are my professional constituencies, long-term care affects far more individuals of all ages, both children and adults.

In 1989, an estimated 7.1 million elderly Americans and about 5 million nonelderly adults and children will need some long-term care services. I point that out because it's not just an issue of the elderly; 40 percent of the people requiring long-term care are actually under the age of 65.

The vast majority of long-term care is provided in the community by family members and friends. It's not a nursing home issue. Over 70 percent of all long-term care services are provided in the community, not in institutions; 85 percent of home care is provided by family members and friends, not by professional caregivers.

And, I wanted to note that these caregivers themselves, who are providing this long-term care, are a vulnerable population in and of themselves. One-third of them live in poverty, one-third rate their own health as fair or poor, and in terms of Alzheimer's families, one-third exhibit the symptoms of clinical depression. So, we need to bolster this long-term care network.

Long-term care expenses are by far the most devastating health care expenses for older Americans. There's almost no public insurance. Medicare covers less than 2 percent, private insurance less than 1½ percent. Medicaid is available only to the impoverished and, primarily, for nursing home services.

The Ohio Long-Term Care Action Network subscribes to a set of legislative principles, and I'll go through them briefly. There's just 10 legislative principles.

One is that it be available to all, that, in fact, anybody, regardless of age or income, would be eligible, and that eligibility would be based on a functional, cognitive, and behavioral assessment of need.

No. 2 would be that it's comprehensive services, that we provide facility-based and community-based health, social, and support services, and that we try to have services that maintain independence and enhance the person's functional abilities.

Three is that we have a broad-risk pool, that we talk about having a broad social insurance program, similar to Social Security or Medicare.

Four is that it bolster informal caregivers. We are not trying to replace the wonderful informal caregivers in our community, but to give them support and services and let them still be the primary care coordinator, that we give them training, et cetera.

Principle No. 5 is that we have progressive financing, that we develop a means as progressive as we can.

Six is that we protect the low-income families from out-of-pocket expenses.

Seven, high quality and easy access for all. Everybody should be able to get these services.

Eight is cost containment; we should be minimizing the public cost of this program.

Nine is that we have an orderly implementation, that it be phased in, that the program have time to develop the array of services necessary.

And, 10, that the States be encouraged as they administer the program to be innovative and flexible.

So, the Ohio Long-Term Care Action Network applauds the appointment of the Pepper Commission. We are really excited about that. We are willing to work with you in any way possible to implement a long-term care program in the country.

American families, 8 out of 10, are already experiencing long-term care or will in the near future. It's really not a problem of individuals or even families, it's a societal problem, and the time for action is now.

[The prepared statement of Ms. Eckert follows:]

Testimony for Field Hearing of Pepper Commission
July 6th in Cleveland, Ohio

Good morning. My name is Sharen Eckert and I am here as a representative of the Ohio Long Term Care Action Network. I have a personal, professional, and community interest in long term care.

My personal interest stems from the fact that my father and his identical twin brother both died last year after battling Alzheimer's Disease for about twenty years. They both retired early -- my uncle at age 55, my father at age 60 -- because each knew that he was already impaired enough to be unable to perform his job effectively. In their mid-sixties, Clayt and Clair were both diagnosed as having Alzheimer's Disease. At age 75, four months apart to the day, these twin brothers both died of this devastating disease.

For all but the last few of these twenty years, Clayt and Clair were cared for in their homes by their wives. As you know, long term care is not just an individual problem but a family problem as well. As with many children, I re-located from California to Cleveland ten years ago to help share the care of my father. An entire family must marshal its reserves to begin to provide care over the five, ten, fifteen, or even twenty year period required.

Professionally, I am currently the Executive Director of the Cleveland Chapter of the Alzheimer's Disease and Related Disorders Association. The Alzheimer's Association sees the availability of long term care services as one of its primary public policy agendas, second only to increased research efforts to eliminate this disease.

There are an estimated 40,000 to 50,000 people afflicted with Alzheimer's or a related dementia in the five-county area we serve. Four million are afflicted nationwide. In most cases, a diagnosis of Alzheimer's Disease ensures that an afflicted individual and those charged with his or her care will be involved in long term care. The operative words here are "long term" -- Alzheimer's caregiving involves intense, "36-hour" days stretching into the future a decade or more.

In terms of my community interest in long term care, I chair the Advocacy Network, which is the public policy committee of the Western Reserve Area Agency on Aging. I am also a member of the Ohio Long Term Care Action Network, a statewide coalition of senior citizen, church, union, advocacy, and professional organizations. The Ohio Network works closely with the national Long Term Care Campaign -- a coalition of almost 130 organizations. This national effort demonstrates the widespread public interest in long term care -- the Long Term Care Campaign is the largest coalition of organizations formed around a single issue since civil rights.

The Ohio Long Term Care Action Network is a coalition of organizations dedicated to enacting comprehensive legislation to protect American families against the devastating costs of long term care. The membership of the Network reflects the diversity of people impacted by long term care. Although it certainly is of concern to the Alzheimer's families who are my constituents professionally, long term care affects far more individuals of all ages -- both children and adults.

In 1989 an estimated 7.1 million elderly Americans and about 5 million non-elderly adults and children will need long term care. Please note that long term care is **not** solely an elderly issue -- 40% of the people requiring long term care are under the age of 65.

The vast majority of long term care is provided in the community by family members and friends. Over 70 percent of all long term care is provided in the community rather than in institutions, and 85 percent of all home care is provided by family members and friends. These caregivers themselves are a very vulnerable population. One-third of family caregivers live in poverty, and one-third rate their own personal health as fair or poor. Studies have indicated that one-third of all Alzheimer's caregivers exhibit the symptoms of clinical depression.

Long term care expenses are by far the most devastating health care expenses for older Americans. There is almost no public insurance coverage for long term care. Medicare covers less than 2 percent, and private insurance only 1.4 percent. Medicaid is available only to the impoverished and then, primarily, for nursing home care. Thus, a national, universal, social insurance program is needed to provide long term care protection to Americans of all ages, regardless of income.

The Ohio Long Term Care Action Network subscribes to a set of ten legislative principles for this public program:

1. **Available to All**: Long term care services should be available to all who need them regardless of age or income. Eligibility should be based on functional, cognitive, or behavioral limitations, or health, or the need for support or training.
2. **Comprehensive Services**: A national long term care program should provide a comprehensive range of both facility-based and community-based health, social, and support services. Services should be provided so as to maintain and enhance personal independence and in a setting preferred by beneficiary and family.
3. **Broad Risk Pool**: The financial risk of long term care should be spread as broadly as possible, through a social insurance program similar to Social Security or Medicare.
4. **Informal Caregivers**: The new public program should assist families and other informal caregivers. Families and friends should be an integral part of care coordination and should have access to supportive services and training to facilitate their caregiving.
5. **Progressive Financing**: The new public program should be supported through sources of financing that are as progressive as possible.

6. **Protection for Low Income**: The long term care program should protect low and moderate income persons from out-of-pocket costs.

7. **High Quality and Easy Access**: The program should ensure access to high quality services for all. Care coordination and caregiver training should be integral parts of the program.

8. **Cost Containment**: The long term care program should minimize the public costs of the program while meeting consumers' needs.

9. **Orderly Implementation**: The program should be phased in over time to ensure orderly development of the new system and all its services.

10. **State Administration**: States should be encouraged to be innovative and flexible in administering and delivering long term care services. Research should be conducted on the adequacy of services to meet family long term care needs and on the development of more accurate measures of disability.

The Ohio Long Term Care Action Network applauds the appointment of this Pepper Commission. We are willing to work with you in any way to best further the development and implementation of a long term care program in this country.

Eight of ten American families have already experienced a long term care problem, or will in the near future. This is not a problem of individuals, nor of families, but it is a societal problem -- the time for action is now. Thank you.

Sharen Eckert
Alzheimer's Association
12200 Fairhill Road
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Chairman **Oakar**. Thank you, Sharen, for your excellent statement.

Ms. **Eckert**. Thank you.

Chairman **Oakar**. Ken Campbell is right in front of me. He is with the Ohio Developmental Disabilities Planning Council, and is the director of their health insurance task force.

Thanks, Ken.

STATEMENT OF KEN CAMPBELL, EXECUTIVE DIRECTOR, OHIO DEVELOPMENTAL DISABILITIES PLANNING COUNCIL, REPRESENTING HEALTH INSURANCE TASK FORCE

Mr. **Campbell**. Actually, I am Ken Campbell, and I'm the director of the council, and I'm here representing the health insurance task force of that council.

Chairman **Oakar**. All right.

Mr. **Campbell**. The council is charged with advocating for systemic changes that will prevent developmental disabilities and enhance opportunities for persons with developmental disabilities to live independent and productive lives within the mainstream of our society.

We have found that the lack of available, affordable, and comprehensive health coverage is one of the strongest barriers to that goal.

I'd like to address each of these segments, unavailability as a key beginning point. Because of what was talked about earlier today, in terms of preexisting condition clauses, there are many people who find a total unavailability of insurance coverage. And, if we look at Toner's, Who Writes What?, this is the underwriting directory that insurance agents often use, we find that, for example, no carrier in the Nation offering coverage on preexisting conditions offers coverage on preexisting conditions such as cerebral palsy, grand mal epilepsy, juvenile arthritis, juvenile diabetes, or early-age head injury. Coverage might be offered on some other preexisting conditions, such as allergies or localized arthritis, but with permanent exclusions on claims regarding those conditions.

So, even if we find coverage at the national level for some of these disabilities, the coverage itself is somewhat useless because it doesn't cover the major issue in their lives regarding the medical circumstance.

Chairman **Oakar**. That's very true.

Mr. **Campbell**. We have the inaffordability aspect also to look at. Coverage may be available, but the premiums, riders, deductibles, and copayments that exist are prohibitive in terms of the expense involved. Of the disabled population in this country, 66 percent is unemployed. Part of the reason for that unemployment has to do with the inability to get health coverage, and the result of that unemployment is, they can't afford payments for what is considered to be available health coverage.

We have a situation where, in this State and in other States, people have looked toward high-risk pools as a potential for solving the problem, and for some people it does tend to address the problem, those middle class, or upper middle class, or wealthier individuals that can afford the rates of risk pools. Unfortunately, again, most people that are dealing with disabilities don't have the wherewithal financially to do that.

We find that medical expenses currently comprise the greatest single explanation for personal bankruptcies in the country, and so, with the situation again with Toner's, Who Writes What?, indicating that this circumstance is only growing worse by virtue of what is offered, what is being offered in terms of insurance coverage.

We find that in the case of preexisting conditions, and riders which reduce the serviceability of a policy, we used to see 6-month exclusions, now we are moving toward 12-month exclusions in that arena of preexisting condition clauses. No one who requires medication can wait 12 months for their insurance to kick in and take care of that kind of a problem.

We have copayments that were once at the 20-percent level. We see them moving toward the 30-percent level, again, the affordability issue.

And then, another issue I'd like to address is an issue of discrimination, and that is the issue of a very suspect practice within the insurance industry of denying coverage or charging higher rates for coverage that is based specifically on a stigmatizing label that a person may carry in regard to their particular disability.

We lack, as a Nation, valid actuarial data to establish what a person with a disability should be paying for their coverage, and, as a result we overcharge. I, myself, have spina bifida, and spina bifida is a disability that is an incompletion of the spine. If it happens at the base of the neck, it's a much more disabling condition than if it happens in the lower back. And so, the degree to which that disability affects my personal health care needs is much different than it might affect someone else. However, when I write spina bifida on a form, the response to that within the insurance industry is as if there's actuarial data that says I'm going to need a lot of health care. I don't necessarily have that situation. I'm quite healthy. I haven't missed a day of work in years. However, the term spina bifida triggers a very discriminatory practice.

Chairman OAKAR. It's varied. We are so glad you are testifying, and I hope all of you know, even though you are the last panel, how important your testimony is. That's really an important point.

Mr. CAMPBELL. I think that the myth is even carried to a greater degree in a communication that we got from a parent of an individual who has Down's syndrome. Mental retardation, as some of us know, is associated with slower development of an individual, and some mental incapacity, but not particular medical urgency or health care needs on a continual basis of an expensive nature. But, a letter that we got from a parent reads like this: "As parents of our Down's syndrome daughter, we were forced to look for new health insurance. We were turned down flat. No company, including major and small, would cover our daughter. She is in perfect health, attends school every day, and has only frequent ear infections. We cannot believe that these insurance companies will not cover her medical needs. It's just really unfair. Something has to be done to protect these innocent children."

This is a matter of, again, through the stigmatizing of a label, assuming that someone's health care is dependent on that.

We find that also a major issue is the inadequacy, the inability to cover a person's needs. Someone with epilepsy that has insurance and is working may not have their prescriptions covered. Someone who has need for—an amputee, that has need for a prosthetic device, quite often does not find that to be a covered service. Occupational and physical therapy are quite often not on the list of covered services by people that are working and have insurance, but it just doesn't meet their needs.

So, we find it to be totally inadequate to meet the needs of persons with disabilities.

I'd like to summarize in closing in terms of our recommendations. We are building a case of recommendations at this time and would like to be in continued communication with you about that. However, we do encourage particular attention be given and investigation be given to the Canadian plan, as has been mentioned, a mix of national or a configuration of coordinated public and private sector kind of funding mechanisms, possibly similar to but not exactly identical to the Canadian plan. We will be coming up with a recommendation from our particular task force by fall in this particular area.

Chairman OAKAR. We'll still be writing the report then, I'll tell you right now.

Mr. CAMPBELL. We believe very strongly in cost containment. We've heard some statements made about the need for cost containment. We feel that there are—there is very much validity in saying that the waste within the system could pay for a correction of the system.

And, with that, you have a copy of the testimony, and I appreciate the opportunity.

[The prepared statement of Mr. Campbell follows:]

UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

Testimony of

Ken Campbell, Executive Director
Ohio Developmental Disabilities Planning Council

On Behalf of
The Health Insurance Task Force of the
Ohio Developmental Disabilities Planning Council
Regina Sweeney, Chair

July 6, 1989

Cleveland, Ohio

Representative Oakar and Members of the Commission, I wish to thank you for holding this hearing and for my own opportunity to provide testimony today on health care issues facing persons with developmental and other disabilities. I am Ken Campbell, Executive Director of the Ohio Developmental Disabilities Planning Council, and am representing our Health Insurance Task Force. The Council is funded under the Developmental Disabilities Assistance and Bill of Rights Act, as amended, and is charged with advocating for systemic changes that will prevent developmental disabilities and enhance opportunities for persons with developmental disabilities to live independent, productive lives within the mainstream of our society.

Representative Oakar and Members of the Commission, I will say at the outset that the lack of available, affordable, and comprehensive health coverage is one of the rock-solid barriers that keeps persons with developmental and other disabilities from being independent, or being productive, or being fully integrated within their communities.

The existence of these hearings around the nation illustrates your common concern about the health care crisis facing almost one in five Americans. In my limited time, I want to accentuate several of the most important ways that the shortcomings of our system of health care discriminate against persons with developmental disabilities, a minority of the 37,000,000 uninsured persons, but ones whose lives and citizenship are inordinately controlled by health issues. Those with most need are increasingly most excluded.

Secondly, I wish to emphasize the economic, social, and psychological isolation that results when persons with disabilities want to enter the competitive workforce, but cannot for lack of health coverage. It is too great a risk to forfeit coverage under Medicaid or other public assistance, if it will not be available through one's employer or a private, individual policy.

And last, on behalf of the Health Insurance Task Force of the Ohio Developmental Disabilities Planning Council, I would like to urge that this Bipartisan Commission's report to Congress recommend firm and deliberate action to implement a public policy of accessible, affordable, and comprehensive health coverage for all American citizens. With Independence Day so close at hand, it is a most fitting time to begin to act upon the innate relationship between personal health and "Life, Liberty, and the Pursuit of Happiness."

PROBLEMS OF ACCESSIBILITY

Unavailable

The most obvious health coverage shortcoming facing persons with disabilities is that it is often simply unavailable, either because it cannot be bought or is too expensive to buy and sustain. In the worst case, individuals are not eligible for government categorical programs such as Medicaid or Medicare, do not have employer group benefits, and cannot purchase individual policies on the open market. Whether in conversation with agents, or in completing extensive health status questionnaires designed to identify existing health problems or family histories of serious or chronic illness, individuals run into the code phrase "pre-existing condition." A profit-oriented private insurance industry, traditionally negative toward those with adverse health histories, increasingly invokes the phrase, "risk not acceptable."

It is paradoxical that one of the major shortcomings of health coverage in America is that the insurance industry seeks to offer policies only to those who are healthy and will be unlikely to use their services. Yet, in the existing entrepreneurial context, substantial losses among major carriers have resulted in scores of companies withdrawing from health care in order to focus upon other lines with promising economies. The bottom line for persons with developmental and other disabilities is that coverage options through private, individual policies are drying up. Cost containment has dramatically reduced availability.

One way to illustrate the problem is by examining Toner's Who Writes What, the underwriting directory insurance agents consult if their own agency will not offer coverage to a particular person, but they hope to identify someone else in the nation who will. Toner's is not an ideal research tool. Agencies need not be listed; some will offer coverage on a given condition, but do not want to advertise it; some will list coverage then reverse themselves when contacted. The two important points to be made are that Toner's is the agents' only national referral guide, and that listed coverage for persons with disabilities is dwindling rapidly.

As reported by an insurance agent working with our Task Force, Toner's currently shows no carrier in the nation offering coverage on pre-existing conditions such as cerebral palsy, grand mal epilepsy, juvenile arthritis, juvenile diabetes, or early age head injury. Coverage might be offered on some other pre-existing conditions, such as allergies or localized arthritis, but with "permanent exclusions" on claims regarding those conditions. Individuals thus face denial on the very health exigencies where they are likely to have service needs. I would prefer that the Commission hear this story of exclusion through individuals who have written to us, when learning that our Health Insurance Task Force was being established:

> "The Task Force is God sent. I have lost count of the insurance companies that I have contacted, concerning insurance for a pre-existing condition."

> "My company's group hospitalization was discontinued by the insurance company because they no longer wanted to write small groups. Brian, age 16, is included in this group. In looking for a company, one flat out refused to cover Brian because of mental retardation (no Doctor report, just policy of the company). They would write the rest of our group. So the agent suggested that we shop for an individual policy for Brian. Again, one company, who the agent thought would write Brian refused before any application was formally made. We did find a company who said, no problem, so we filled out the application. He was rejected, based on his height, weight, and Doctor's report."

Unaffordable

The other aspect of inaccessibility--unaffordability--is an extension of outright exclusion. Coverage may be available, but with premiums, riders, deductions, and co-payments that are prohibitive. The inability of individuals to afford available coverage may be best illustrated through the experience of various States' efforts to provide "last resort" coverage through legislated "High Risk Pools." Even where states attempt to ensure an option, premiums are excessive, with high deductibles and co-payments. The current bill under consideration in Ohio allows rates to range as high as 175 percent of the standard individual rate charged by the five largest insurers offering individual coverage--and experiences in other states have indicated that rates tend to seek the highest ground. Combined with large deductibles and co-payments, state High Risk Pools have been recognized, even by their foremost proponents, as options generally available only to upper-middle class and wealthier individuals. They are well intentioned, and help some persons with disabilities. But they are not available to most persons with developmental disabilities who may have to spend one-third to one-half of their income to utilize them, and become dangerous when offering the illusion that a severe health care gap has been patched.

Lack of affordability is also expressed by the same high premiums, deductions, and co-payments on the open market. They are requiring sacrifices ranging from extreme financial hardship to bankruptcy. Cost-shifting to the user by private insurance companies, in difficult recent times, helps to account for those who have been forced to drop available coverage, as well as to explain the fact that medical expenses currently comprise the greatest single explanation for personal bankruptcies. Our insurance agent's examination of Toner's Who Writes What again indicates ominous trends where coverage is offered. Pre-existing conditions riders, once traditional as a 6 month exclusion, are now moving toward 12 month or permanent exclusions. Co-payments that were once 20 percent for the policy holder, up to a certain obligation cap, are now moving toward 30 percent, and caps on policy holder obligations are being removed. Again, I would like to illustrate how families are affected by referring to those who have contacted us:

> "I am one out of seven that cannot afford health insurance. I work full time with no benefits and have difficulty even purchasing the medication needed for hypertension. When I can buy the prescription, I only take 2 pills a day, instead of the 3, to try and stretch them out. My doctor can verify that I need extensive tests and lab work, but I am still trying to pay off the hospital and doctor bills from over a year ago. I fear the day when I can no longer force my body to go to work."

> "Our child (age 5-1/2) has head injury. I feel from talking with other individuals with and without insurance that we are luckier than most because we have better insurance and still we have paid more than $8,000 out of pocket over the past 3 years. We pay our doctors before we buy food."

> "Shannon was in the hospital for surgery in July of 1988. Her bills totalled over $103,000. Our insurance has a $200,000 for life maximum on it. We hardly have any left on her and she is going to have more surgery in August. Shannon is only 12 years old and if she lives we will not have any insurance at all for her. We do not receive S.S.I., so therefore she cannot get Medicaid. This is a constant worry for us. I hope there is something you can do to help people with 'Special Children' and handicapped people, with insurance."

Discriminatory

The third element of inaccessibility concerns its discriminatory nature. Since no right to health care has been advanced by the Constitution or courts, we are not in a position to assert discrimination on a par with violations of established civil and political liberties. Similarly, insurance enterprises are private businesss forces, rather than social service agencies, and we cannot expect moral obligation to supercede calculated fiscal projections which assure the economic health and survival of companies. Yet, the federal government entitles only certain groups to health care, and private insurance enterprises--the nation's primary health financing mechanism--combine, through inaction and exclusion, to create inequitable circumstances that are discriminatory in effect.

Insurance enterprises are suspect in denying coverage, or charging higher rates for the same coverage, or limiting benefits to individuals with stigmatizing labels because they lack valid actuarial data which establish cost references for individuals with particular conditions. Industry resources indicate that since high health care utilization may be expected of some persons with a particular condition, the industry has been negative to all persons with that condition. Data which would establish underwriting standards have not been rigorously pursued, and that which is available tends to be withheld from public review as a proprietary right of private business.

On the other hand, studies repeatedly indicate wide ranges of health status within conditional categories, as well as the fact that small minorities of individuals within groups account for large majorities of health services costs. Persons sharing a label with others may be excluded from or limited in coverage, though demonstrating personal histories of average or sub-average health service utilization.

Mental Retardation, for example, is typically defined by subaverage general intellectual functioning and deficiencies in adaptive behavior. Though some persons with mental retardation may also have adverse health histories, the condition is better associated with slower development than medical urgency. We are still working diligently to increase understanding of this condition among the general public. But the insurance industry is one of the better examples of the fight we face and, in fact, becomes a segregating force as persons cannot gain the insurance that will allow them to work, and increase positive understanding through personal interactions.

I ask you to consider the overt feelings of discrimination expressed in the following excerpt of a mother's letter to our Task Force:

> "As parents of our Down's Syndrome daughter, we were forced to look for new health insurance. We were turned down flat. No company, including major and small, would cover our daughter. She is in perfect health, attends school every day, and has only frequent ear infections. We cannot believe that these insurance companies will not cover her medical needs. It's just really unfair. Something has to be done to protect these innocent children."

Inadequate

The final aspect of inaccessibility that I will address involves limitations on coverage for disability-related expenses which result in inadequate levels of care according to the special needs of individuals. This may include lack of adequate provision for medications or services deemed medically necessary by licensed physicians, as well as needs which may not fall within a medical definition, but are necessary to meet the ongoing maintenance requirements of individuals. Points of dispute often center upon limitations or exclusions of coverage for durable medical equipment, prosthetic devices, occupational and physical therapy, assistive equipment, home health care and personal assistance, and disposable medical supplies necessitated by bodily functions.

While my time is too limited to delineate services that are often condition-specific, suffice that persons with epilepsy have ongoing medication needs, yet prescription drugs are often not fully or partially covered; amputees have ongoing needs for prosthetic and orthotic devices and services, yet these are frequently not covered benefits; those who are paralyzed or non-ambulatory require wheelchairs to function, but benefits often are not provided for purchase or repair. In short, adequate levels of care are not accessible because of inadequate coverage, though persons are insured. Again, I will refer to the letter of an individual who can speak about these needs from personal experience:

> "Not only are we, as amputees, caught with the 'pre-existing condition' clauses, but worse, have little to no coverage for prosthetic and orthotic devices. Most private underwriters will not allow any prosthetic or orthotic devices, calling them 'cosmetic' and 'luxury goods' and further, stating that they are 'not necessary to function.' I don't function well at all without my artificial leg. The few insurance carriers who provide orthotic and prosthetic services, do so in such limited ways as to be useless. Most allow only one limb in a person's lifetime and one to two repairs in that same time-frame."

DISINCENTIVE TO EMPLOYMENT AND COMMUNITY INTEGRATION

Our second theme is particularly pertinent since the special health insurance problems of America's small businesses and their employees have been designated as the major focus of this Cleveland hearing. It is equally pertinent when we read headlines about the shrinking labor pool; or hear that major fast food chains have a 400 percent annual employee turnover rate; or see strings of Help Wanted signs as we drive down the street.

Persons with disabilities want to work, and work well. They are a good match for the manpower needs of commercial interests of all sizes, but perhaps especially so for the smaller business. The match often does not take place because of a fundamental barrier. Employers hiring persons with disabilities, especially in part time and minimum wage roles, often fail to provide health insurance benefits, and individuals cannot forfeit coverage through Medicaid or a parallel federal program when private coverage cannot be purchased. When they are successful at work, mounting earnings will cross the Substantial Gainful Activity threshhold and, paradoxically, health care will be lost.

People with disabilities want to work! In fact a major survey of the self-perceptions of persons with disabilities, conducted by the Harris organization, recently demonstrated that respondents preponderantly prefer jobs to federal subsidies. Similarly, research and employer reports typically indicate that workers with disabilities--with appropriate placement, training, and support--are eager and productive employees. They manifest their work enthusiasm in very objective ways, including punctuality and lower rates of absenteeism and turnover than the general workforce. It is this kind of successful experience that has led major corporate enterprises such as Quaker Oats, Marriott Hotels, and Steelcase, not only to accelerate affirmative hiring of persons with disabilities, but to take leading advocacy roles in alerting their peers to this cost-effective, stabilizing workforce option. Like persons with disabilities who want a chance, not public assistance, progressive employers are seeing their hiring as sound business practice, not charity.

Organizations which promote the independence, productivity, and integration of persons with disabilities into the mainstream are particularly attuned to the part employment plays in enhancing social, as well as economic, participation. In our society, work is the core of self-worth and interpersonal respect, as well as security and material choices. Working and paying taxes produce internal sensations and attitudes from others that are fundamentally different from the stigmas of joblessness and public assistance. Society profits as well, when persons with disabilities are positioned to pay taxes and purchase insurance, rather than draw from taxpayer subsidies. Health coverage is the key to releasing not only these productive forces but other Human Services populations, such as persons on welfare, who simply cannot realistically be expected to sacrifice health coverage for themselves or their families for entry-level jobs where coverage alternatives are not available. The problem is capsulized in a letter from a Client Benefits Coordinator at one of Ohio's County Boards of Mental Retardation and Developmental Disabilities:

> "Our agency advocates competitive employment for persons with disabilities and yet we cannot answer the question, 'what will I do if I am not eligible for Medicare and/or Medicaid?' If we were offered a chance to increase our income in the job market but no health plan was available, how many of us would be willing to take the risk?"

RECOMMENDATIONS

The Ohio Developmental Disabilities Planning Council's Health Insurance Task Force is currently concluding its own more detailed findings and recommendations, which will be forwarded to you immediately upon completion. However, I want to note three clear guidelines that the Task Force wishes to be brought to your attention at this time.

First, the Task Force recommends that these hearings become a foundation for generating deliberate national policy, along with deliberate national planning, that will result in the provision of equitable and affordable access to health care services for all Americans. While the national government is urged to assume the moral obligation and responsibility for meeting this society-wide challenge, we do not at this time advocate a particular national model, or a particular configuration of coordinated public and private sector funding mechanisms.

We do, however, urge investigation of practices within the Canadian approach, primarily because the Canadian experience has indicated that a nation can achieve equitable access, with high quality basic care, while more successfully containing costs. Similarly, we recommend consideration of serious proposals for a national health insurance plan, appearing in the New England Journal of Medicine and elsewhere, which build upon the Canadian approach, but are intended to adapt that model to American economic and cultural characteristics, including a public and private sector financing mix.

Second, the Task Force recommends that such a national plan reflect a commitment to an adequate level of care for all individuals, according to and including the special needs of individual health conditions. All medically necessary services must be provided, including flexibility for a range of services that may not be strictly medical, but are necessary for the ongoing maintenance of individuals at appropriate levels of care.

And last, we urge that such a national plan actively address cost containment through better utilization of monies currently consumed by the American health financing structure. It may seem ironic that we advocate expanded access and coverage for high risk individuals at a time when our most stringent cost containment efforts cannot keep health care inflation below 20 percent per annum. Instead, we ask that this nation come to grips with waste and excess, redirecting toward health a piecemeal health provision system characterized by open-ended fees for service; overcapacity; excessive administration, bureaucracy, and public relations; unnecessary diagnostic and surgical treatments; biases toward high technology, institutional, and expensive practices; and similar recognized, but undeterred, elements of our inflationary health care spiral. The Task Force seeks a national approach that will not ask who we can exclude in order to pay less, but how we can serve all through better spent dollars.

As I conclude this testimony, I want to assert the idea that the development of a health care system with equitable and adequate services for all, is for all--not just a magnanimous gesture to those without. It is bedrock to a national ideal which affirms life, the individual, and equality of opportunity. It is a collective moral obligation in a society which prides itself upon E Pluribus Unum. And it is now evident that the nation's competitive trade posture is being severely injured as American exports carry excess costs associated with manufacturers' health care costs, versus the less expensive products of international competitors, where universal coverage has proven to be more cost-effective.

But if this advocacy for equitable coverage can be seen as politics, please allow me to make the politics personal to all of us. In the disability field, advocates sometimes try to get the attention of those fortunate enough to enjoy good health by calling them TAB's, ("the Temporarily Able-Bodied.") The acronym captures the unpredictability of the future and advises that any of us, or those most close, might one day be classified among groups with disabilities or chronic illnesses. We all will age; many will have unanticipated, but tragic, accidents; some will have children or grandchildren, nieces or nephews, who are born with, or develop, chronic disabilities. All of us may come to know, first-hand, that personal health is unpredictable, disability is usually undeserved, and health coverage may be unavailable or bankrupting.

My point is that when public policy condones a fragmented health coverage structure, where government programs entitle some, but not others, and our primary health financing mechanism, the private insurance industry, underwrites on a rate for risk basis, groups will be left in the cold. Any American citizen currently insured may enter the ranks of the excluded by virtue of the unpredictability of disability and chronic illness. And so, it is not a case of us, who are covered, and them, who are not. In the future, those others may very well be any one of us.

Representative Oakar and Members of the Commission, your consideration of this testimony is greatly appreciated.

Chairman **Oakar**. Thank you very much, excellent testimony again.

We have one last witness who has asked to testify, and I will acknowledge Alma Krekus, who will talk briefly, because we are running behind. We are so delighted to have our television stations here, but they are running out of tape, so we want to make sure we get a complete taping when we play this, you know. It will be helpful to us.

So, Alma, why don't you proceed for about 2 minutes, OK?

STATEMENT OF ALMA KREKUS, ATTENDANT CARE COORDINATOR, SERVICES FOR INDEPENDENT LIVING AND CHAIRPERSON, OHIO PERSONAL CARE ASSISTANCE PROGRAM

Ms. **Krekus**. Thank you very much.

My name is Alma Krekus, and I'm the attendant care coordinator of Services for Independent Living, and I'm concerned with independent living.

I would like to testify about long-term care for several reasons. First, I have had the unique experience of living in this society as both a person without a disability and a person with a disability, and I'm also from a country that has socialized medicine.

Second, I would like to say that long-term care is not just for the elderly. Babies are born with disabilities, people of all ages are injured in all kinds of accidents, and people at the peak of their lives are diagnosed with long-term illnesses.

As the attendant care coordinator of an independent living center, I am in touch with people with many kinds of disabilities. It is the goal of our attendant care program to help people with disabilities locate help and/or programs so that they may take care of their daily needs in order to live independently.

The monthly income of the majority of these people is under $400, from which they pay their rent, food, phone, and with what is left they hire an attendant to help with their daily care, which the nondisabled community takes for granted, such as bathing, dressing, transferring in and out of bed, bowel and bladder care, and so on, all basic human needs.

I interviewed a young man recently who was injured from a gunshot wound, and he is paralyzed from the neck down. He will be spending the rest of his life on a ventilator. His young wife will be his main caregiver, and is being trained to take care of him. Doctors and technology are doing wonderful things for people. I know eight who are ventilator-dependent, but, unfortunately, there seems to be no adequate program for their long-term care.

A young woman I know has been paralyzed for about 5 years from a spinal cord injury. She recently spent some time in a rehab unit, and after a few weeks the therapist had her up and walking at the parallel bars. She has not walked for 5 years. However, Medicare would only pay for so many weeks for her to stay at the rehab center, and she was sent home. Just think, if there were adequate programs, she might be walking on her own today.

Third, I am the chairperson of the Ohio Personal Care Assistance [PCA] Program. It is funded by the State and was started 6 years ago, paying $4 an hour, up to a maximum of 35 hours a week, to 54 severely disabled people. This program has proved to be cost effective, but funds are very limited. The program has not been publicized, but we now have almost 200 people in it, with a waiting list of over 220.

Medicaid and Medicare also pay for this type of care, and so do some private insurances, but none of these programs are adequate. The PCA Program does not have the funds it needs. Medicaid and Medicare are difficult to understand and access, and vary from county to county.

If there could be a networking of the already existing programs to make them more understandable and accessible, this would enable more people to be served and, perhaps, eliminate some of the duplication of services that others obtain. This still would not be adequate, but would contribute toward a national long-term care program.

Thank you.

[The prepared statement of Ms. Krekus follows:]

TESTIMONY
Alma Krekus
6257 Chase Drive
Mentor, Ohio 44060
257-9380 (H)
731-1529 (W)
July 5, 1989

REPRESENTATIVE MARY ROSE OAKAR AND MEMBERS
OF THE LONG TERM CARE COMMITTEE

I would like to testify about Long Term Care for several reasons.

Firstly, I have had the unique experience of living in this society as both a person without a disability and a person with a disability and I must say that living with a disability is hard work, time and energy consuming and expensive.

I was injured in a freak accident 21 years ago which left me paralyzed from the chest down - a paraplegic. This means that I have no feeling, no movement and no control over the lower half of my body because of a Spinal Cord injury. I am not sick but I do need "maintenance" medications and incontenent supplies, which cost about $2000 a year, for my bowel and bladder care. Our family health insurance has never covered these expenses, nor the cost of my wheelchairs which my husband has repaired himself these past 20 years.

Secondly, I would like to say that Long Term Care is not just for the elderly, but everyone; babies are born with disabilities, people of all ages are injured in all kinds of accidents and some people, at the peak of their lives, are diagnosed with a long term illness.

As the Attendant Care Coordinator of an Independent Living Center, I am in touch with people with many kinds of disabilities all day long. It is the goal of our Attendant Care Program to help people with disabilities locate help and/or programs, so that they may take care of their daily needs in order to live independently.

The income of the majority of these people is under $400 from which they pay their rent, food, phone and, with what is left, they hire an attendant to help with their daily care, which the non disabled community takes for granted, such as bathing, dressing, transfer in and out of bed, bowel and bladder care, and so on - all basic human needs.

I interviewed a young man recently who was injured from a gun shot wound and he is paralyzed from the neck down at the C-2 level. He will be spending the rest of his life on a ventilator. His young wife will be his main care-giver and is being trained to take care of him. They have a 3 year old child and no money for outside help. I don't know how she will be able to manage alone. Doctors and technology are doing wonderful things for people (I know 8 who are ventilator dependent) but, unfortunately, there seems to be no adequate program for their Long Term Care.

A young woman I know has been paralyzed for about 5 years from a Spinal Cord injury. She recently spent some time in a rehab unit because she was in excruciating pain. After a few weeks the therapists had her up and walking at the parallel bars. Imagine - she has not walked for 5 years. I almost cried when I saw her. However, Medicare would only pay for so many weeks for her to stay at the rehab center, and she was sent home. She became so depressed that she ended up in another hospital with depression. Just think, if there were adequate programs she might be walking on her own today!

Thirdly, I am the Chairperson of the Ohio Personal Care Assistance Program. It is funded by the State of Ohio and was started six years ago paying $4 an hour up to a maximum of 35 hours a week to 54 severely disabled people. This program has proved that it is cost-effective but funds are still very limited. Although this program has not been publicized, we now have almost 200 people on it with a waiting list of over 220.

Medicaid and Medicare also pay for this type of care and so do some private insurances BUT none of these programs are adequate. The PCA Program does not have the funds it needs, Medicaid and Medicare are difficult to understand and access, and vary from county to county, and private insurances generally have exclusions relating to pre-existing conditions.

If there could be a general networking of the already existing programs to make them more understandable and accessible, this would enable more people to be served and perhaps eliminate some of the duplication of services that others obtain. This still would not be adequate but would help towards a national Long Term Care Program.

Chairman **Oakar**. Thank you very much, Alma.

Let me just say, Ms. Auburn, I was glad to hear you say you were representative of the needs in the suburban areas, because I think a lot of times people think this is only an inner-city problem, and it's not. I can say that, after representing a good part of the city and all parts of 16 suburbs, this is amazing.

Ms. **Auburn**. Your panel reflected that earlier, too, between Westlake, Strongsville, Euclid.

Chairman **Oakar**. Yes, very interesting, wasn't it?

Ms. **Auburn**. Uh-huh.

Chairman **Oakar**. But, it's certainly a problem for the poor, as well as the not so poor, the people who fall between the cracks, and others. We are delighted to have been here for 5 hours, and I want to thank Ed Howard and all the witnesses, and, certainly the staff of both the Commission and my own staff for all their hard work. It's not an easy thing to put this together, but, I'll tell you, this is a serious national security issue, and I know I speak for many of the Commission members in saying, we want to address this problem and try to do something about it for the sake of our people.

So, thank you all so much, and at this point the Commission is adjourned. Before I do that, though, I wanted to tell you that Ed slipped me a note, and we are going to be having a Commission meeting on the Canadian plan, so we'll be studying these very intimately so that we have the best of all the plans. Hopefully, and we can come up with some solutions.

Thank you all very much. The Commission is adjourned.

[Whereupon, at 2:30 p.m., the hearing was adjourned.]

APPENDIX

TESTIMONY TO THE U.S. BIPARTISAN COMMISSION ON
ON COMPREHENSIVE HEALTH CARE
Thursday, July 6, 1989
Ameritrust Auditorium, 9th & Euclid Avenue
Cleveland, Ohio 44115

My name is Bernice Baker and I am presently giving care to Mrs. Hazel C. Callahan. I am underpaid but I do the best I can out of love and a sense of committment for a friend.

I have worked in many nursing homes (I will not name them) and I can say out of personal experience that some of the most horrible things imaginable happens in them. The food is bad and the care is not adequate. Mrs. Callahan can do nothing for herself - not even wipe the tears from her face. She is not sick, just disabled. Her mind is sharp and her thinking and reasoning are excellent. To put her in a nursing home would be a sin and immoral. She was a contributing member of society and helped many youngsters during her years as a teacher. I must wonder why there is no agency or organization willing to help her in her time of need.

I have worked with others like her and I do this out of the belief that we are all on earth to help others. I get a small compensation but I too get no health insurance coverage nor am I covered under Social Security. Because of this, I feel her pain and frustration.

I pray that this hearing will produce some results for people such as Mrs. Callahan as well as persons in my work situation.

May the spirit of love and compassion be with each of in this hearing.

Thank you.

Bernice Baker
12815 St. Clair Avenue
Cleveland, Ohio 44108

Bernice Baker

CRL

Central Reserve Life
Of North America Insurance Company
343 West Bagley Road Berea, Ohio 44017-1387
216 / 826-4100

June 30, 1989

Mary Rose Oakar
Member of Congress
523 Federal Court Building
215 Superior Avenue
Cleveland, OH 44114-1281

Dear Congresswoman Oakar:

For the official record, Central Reserve Life supports HIAA's position, presented by Carl Schramm to the Subcommittee on Health for Families and the Uninsured, June 19, 1989. We submit his remarks (enclosed) as written testimony for your July 6, 1989 hearing.

As you know, Central Reserve Life is a leading health insurer of small business. Your hearing is of vital interest to our company and a representative will attend.

Thank you.

Sincerely,

Glen Laffoon
Senior Vice President,
Corporate Development

GL/ce

REMARKS

BY

CARL J. SCHRAMM
PRESIDENT
HEALTH INSURANCE ASSOCIATION OF AMERICA

ON

ACCESS TO HEALTH CARE FOR ALL AMERICANS

BEFORE THE
SUBCOMMITTEE ON HEALTH FOR FAMILIES AND THE UNINSURED
COMMITTEE ON FINANCE
UNITED STATES SENATE

JUNE 19, 1989

HEALTH INSURANCE ASSOCIATION OF AMERICA
PROPOSAL FOR UNINSURED AMERICANS

SUMMARY

I. Complex problem because of the character of the population without health insurance.

   A. Thirty percent below the Federal poverty level; 30 percent near poor, between 100 and 200 percent of the poverty level; 40 percent above 200 percent of the poverty level.

   B. Eleven percent are self-employed and their families; 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.

II. HIAA proposes four-point plan:

   A. Reform and expand Medicaid to cover all below the Federal poverty level, regardless of family structure, age, or employment status.

      1. Eliminate categorical restrictions.
      2. Uncouple from eligibility for welfare cash payment.
      3. Income-related "buy-in" of primary and prevention care package for low-income above poverty line.
      4. "Spend-down" program required in all states for medically needy.
      5. Optional "buy-out" program allowing states to pay employee share of working Medicaid eligible's group insurance. Allow transition coverage for those coming off Medicaid.

   B. Allow insurers to offer more affordable coverage:

      1. Extend ERISA preemption of state mandated benefits enjoyed by self-insured plans to insured employee plans.

      2. Allow insurers to market lower cost prototype plans.

   C. Help small businesses afford coverage - 100 percent tax deduction for self-employed as long as they provide equal coverage for employees, if any.

   D. Guarantee availability of private health insurance:

      1. For uninsurable individuals, state pools with losses financed by state general revenues or other broad-based funding; if state doesn't act, HHS sets up pool in that state with losses paid with Federal funds HHS would otherwise spend in that state.

      2. For uninsurable groups, a private reinsurance mechanism with losses equitably spread through the private sector.

I am Carl J. Schramm, President, Health Insurance Association of America. HIAA is a trade association representing some 350 insurance companies who write approximately 40 percent of the health insurance in this country. The combined efforts of HIAA's members, the Blue Cross-Blue Shield plans and HMOs have succeeded in protecting 180 million Americans. However, we recognize that this is not enough.

Mr. Chairman, our member companies are greatly concerned about those 35 to 37 million Americans who do not enjoy the protection of health insurance. Over the last two years, our membership has worked hard to develop creative solutions for extending health care benefits to uninsured groups and individuals. On behalf of HIAA, I am pleased to report a commitment among our companies to work with government in implementing effective approaches for providing coverage to this population.

The task of ensuring that all Americans enjoy the protection of insurance is complex. This complexity is largely a function of the heterogeneity of the uninsured population; this heterogeneity requires a combination of private and public solutions.

Roughly three in ten of the uninsured are poor (with family income below 100% of the federal poverty level); three in ten are low income (between 100% and 200% of the poverty level); and four in ten are non-poor (above 200% of the poverty level).

Eleven percent of the uninsured are the self-employed and their families; 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.

Finally, uninsured workers are disproportionately employed in certain industries (retail trade and services) and by smaller firms.

All of the above factors make formulating any strategy for a public/private solution difficult. As such we see the need to address the special needs of the various subpopulations within the 37 million uninsured with a simultaneous multi-pronged approach. We propose a specific four-point plan which, taken as a whole, provides a comprehensive blueprint to cover the uninsured:

The first part of our recommendations involves expansion of the Medicaid program. The members of this Subcommittee know, far better than I, the intricacies and shortcomings of Medicaid eligibility, and the funding crisis that preserves them. HIAA knows that this Subcommittee has helped lead the fight and has succeeded in enacting important incremental improvements in Medicaid year after year. Because of your instrumental role in developing policy in this crucial area, I plan to spend additional time today discussing some of our latest thinking on Medicaid expansion.

A. Expansion of Basic Medicaid Coverage

Ultimately we would like to see all Americans with incomes below the federal poverty level (and with limited assets) eligible for Medicaid, regardless of family structure, age or disability status. Accomplishing this would require severing the linkage between Medicaid eligibility and cash assistance.

If available funds do not permit full coverage up to the poverty level, HIAA believes priority should be given first to younger children, next to older children and finally to other populations. Priority should also be placed on primary care and preventive services. Unlike some other populations, many poor children do not have access to federal health care financing programs other than Medicaid (i.e., Medicare). This priority also reflects the critical need that children and pregnant women have for preventive services.

B. Limited Medicaid Buy-In

Individuals and families with incomes above poverty but below 150 percent of the federal poverty level should be eligible to purchase first-dollar coverage of a limited package of primary, preventive and related ambulatory care through their state's Medicaid program.

The benefit package would include basic ambulatory services such as well-child care and immunizations, prenatal care, basic diagnostic services including laboratory tests and x-rays, primary treatment services, monitoring of chronic illness, and outpatient prescription drugs according to the state's Medicaid formulary. Inpatient services would not be covered, nor would outpatient drug or alcohol services, mental health services, cosmetic surgery, treatment of infertility, major outpatient surgical procedures, or home health care (other than maternity-related).

Such a limited benefit package meets the near-poor's need for access to basic primary care (so that illness does not become more severe and expensive through lack of treatment), while not significantly lessening employers' incentives to offer basic insurance protection. As employer plans often incorporate a deductible in an amount which would be a relatively significant barrier for the near-poor, there should be only minimal overlap between buy-in benefits and employer-provided coverage.

The limited benefit package keeps costs of the buy-in coverage per se to a minimum, thus permitting very low premiums, constraining government costs, broadening participation, and reducing the chance of adverse selection. (Assuming realistic participation rates by eligible persons, our preliminary estimate of total federal and state costs of the buy-in is in the $1 billion range.)

A sliding scale of premiums should be developed so that, at the upper end of the income range, the charge would approximate the actuarial value of the coverage, not to exceed 15 percent of the family's income in excess of the federal poverty level. We are developing a specific benefit package proposal that would cost about $50-$60 per month for a family of three. If five income brackets were used, for example, the suggested monthly premium charges would be as follows:

Family Income as a Percent of Poverty	Monthly Premium Charge
100 - 109 %	$ 6
110 - 119 %	18
120 - 129 %	30
130 - 139 %	42
140 - 149 %	54
150 % + over	not eligible

Because some public subsidy is involved, eligibility would be restricted to persons with limited incomes who do not have substantial assets. However, the current Medicaid asset test should be liberalized to assure that working families would not have to impoverish themselves in order to obtain access to basic primary care. Homes, and cars of normal value, should be protected. The limit on liquid assets should be liberalized somewhat, perhaps to the $12,000 level Congress recently found acceptable for spouses of nursing home residents. A self-declaration process could be used to minimize administrative burden.

C. Spend-down

Persons not otherwise eligible for Medicaid due to higher income should become eligible for full Medicaid coverage once out-of-pocket medical expenses reduce their remaining income to the federal poverty level.

Some coverage of last resort is needed to cover inpatient care and other large out-of-pocket expenses for the near-poor who cannot afford to purchase private insurance on their own and whose employers do not offer it or offer only very limited coverage. Ensuring such coverage of last resort should be accomplished by requiring that all states establish "spend-down" coverage at the federal poverty level. This would establish a uniform national eligibility policy for the more limited "medically needy" option, now used by 36 states. The asset test should be adjusted to assure that the home, and cars of normal value, would be protected; but, to avoid incentives to drop private insurance, the limit on liquid assets would be left to state discretion, as it is now.

The major current problem with spend-down -- it does not finance early access to primary and preventive care -- is remedied by making "buy-in" available for primary, preventive and related ambulatory care.

D. "Buy-Out"

HIAA also recommends that Medicaid eligibles who are working be encouraged to make use of employment-based health insurance, where it is available. To accomplish this goal, state Medicaid programs should be given the option of paying (and receiving federal matching funds for) the employee's share (if any) of the private insurance premium, as well as other costs. Medicaid would continue to be available to cover deductibles and other benefits not covered under the employer plan; and Medicaid's contribution, for the employee's premium plus Medicaid's "wrap-around" coverage, would not be permitted to exceed the average cost of traditional Medicaid coverage.

Under our proposal, states would have the option of "buying out" two groups. First, more working people will qualify for Medicaid as the income level is raised to the poverty level for more persons and categorical restrictions are removed. Allowing states to pay the employee's premium share for any working Medicaid eligible seems a sensible way to reduce government outlays and encourage reliance on mainstream private, rather than government, benefits.

Second, current public policy supports the concept of encouraging low-income persons to work by easing the transition from public support to self support. One component of this policy is to integrate low-income persons returning to work into mainstream, work-provided benefits while continuing to provide government support for other necessary services during a transition period. The most recent example of this is the Welfare Reform Act, which extends Medicaid eligibility for 12 months after a family loses cash welfare payments because of a return to work and permits states to pay the employee's share of employer-provided health insurance.

As such, states should also have the option of paying the employee's share of available group coverage during the first year after the worker loses regular eligibility for Medicaid. For the first six months after loss of regular eligibility, there would be no income limit on eligibility for this premium subsidy. For the second six months, Medicaid payment of the employee's share could continue only for workers whose family income remained less than 150 percent of the federal poverty level. As under welfare reform, states would be allowed to charge a nominal premium during the second six months, based on the family's income as a percent of the federal poverty level.

For both the "buy out" of Medicaid eligibles and the "buy out" of individuals transitioning off Medicaid, participating employers should be required to make the same premium contribution on behalf of Medicaid-eligible employees as they do for other employees.

We believe that the federal government can rely on states to take advantage of the "buy out" option if and only if it is financially advantageous to the state and the federal government (considering the benefits available under the employer plan and the charge to the employer/state to obtain them.) Since the employee's share of employer-provided coverage will usually be significantly smaller than the amount Medicaid would expect to pay to provide benefits directly, states would probably make extensive use of this option. While states should be permitted to make this decision on an employer plan-by-employer-plan basis, they must not be permitted to discriminate among individual employees.

2) As the second piece of our four point plan, insurers should be allowed to offer more affordable coverage, including prototype plans. ERISA preemption of state mandated benefits should be extended to insured employee plans as well as to self-insured plans so that insurers can design less expensive benefit packages for small businesses.

Ironically, while the more than 600 state mandates do not apply to the vast majority of large employer and union plans (which are self insured) they do apply to most small employers who simply cannot afford them. A study by a respected health economist at the University of Illinois estimates that as many as 16 percent of uninsured small employers fail to offer coverage because of state service and provider mandates.

HIAA will also support statutory changes to enable insurers to make lower cost prototype plans available. All prototypes would be actuarially equivalent in value and include basic inpatient and outpatient physician, hospital and diagnostic services. Additional services, such as dental and mental health, would be offered in some of the prototypes in exchange for higher copayments. In all prototypes, managed care features would be permitted.

3) Coverage must be made available to all Americans. This is true, even for those whom insurers might normally decline due to existing high cost medical or occupational conditions. There are two components to consider here: uninsurable employer groups and uninsurable individuals.

To ensure access to affordable group coverage for all employees, a nonprofit organization should be established to reinsure high cost employer groups. Employers would access the reinsurance organization indirectly via insurers, or directly if unable to purchase coverage through an insurer. Losses incurred by the reinsurance organization could be financed entirely by the private sector if shared equitably among competitors in the small group market and all larger health plans whether insured or self-insured.

HIAA also seeks Federal legislation encouraging all states to enact a qualified state pool for medically uninsurable individuals. Such pools have already been enacted in 17 states. Each pool should be a nonprofit corporation with coverage available only to uninsurable individuals who are not eligible for coverage by employer plans, Medicare or Medicaid. Pool losses should be financed by state general revenues or any other broad based funding mechanism that does not assign losses disproportionately to any individual or corporate entity. In the absence of action by a state, the Secretary of the Department of Health and Human Services (HHS) should establish a qualified pool in that state, in which case losses, if any, would be paid from federal health funds the Secretary would otherwise spend in the state.

4) Small businesses should be given a greater incentive to provide coverage for their employees. Self-employed individuals should get a 100 percent deduction for their health insurance protection, as long as they provide equal coverage to their employees. The 25 percent deduction which expires this year

under current law, should be extended and increased, as provided in S.494, introduced by Senator Durenberger and co-sponsored by members on both sides of the aisle.

Our proposals are designed to meet the needs of a heterogeneous uninsured population. We believe that they should be given an opportunity to work before government turns to unnecessarily onerous mandates. Our four-point plan provides a blueprint for a truly comprehensive approach to solving the problem of the uninsured. The plan stresses the sharing of responsibility between government and the private sector. In our proposal we are calling on government to assist those who cannot be expected to pay for coverage on their own. We in turn will ensure that for everyone who can afford private coverage will be available.

Thank you.

THE PEPPER COMMISSION ON COMPREHENSIVE HEALTH CARE

Hearings at Cleveland, Ohio
Cong. Mary Rose Oakar, presiding
July 6, 1989

Testimony of Alvin L. Schorr
Leonard W. Mayo Professor of Family and Child Welfare
Mandel School of Applied Social Sciences
Case Western Reserve University

Testimony of Alvin L. Schorr
for the Pepper Commission on Comprehensive Health Care
Cleveland, July 6, 1989

Congresswoman Oakar and Other Distinguished Members of the Commission:

I am Alvin L. Schorr, Leonard W. Mayo Professor at the social work school at Case Western Reserve University. I specialize in issues of public policy, and have devoted these last years to issues of health policy. Thank you for the opportunity to present my views.

You will have a great deal of testimony about the need to cover the uncovered, which is indisputable, and about the merits of creating a truly national system versus perfecting our current free market system. I have expressed myself on these matters at various times[1], but I want to devote this time to an issue that you will probably hear less about. This is whether the nation should continue, let alone extend, a two-track system of medical care. To be more exact, the question is whether we should rely extensively on means-testing in the design of our medical care system.

Means-Testing --- a Two-Track System

Means-testing or a two-track system is a method of rationing the delivery of health care; one should begin with this firmly in mind. All systems ration in one way and another --- by making care available to the highest bidder, by organizational constraints (professional review, DRGs), by waiting lists, and so forth. Means-testing is a method of rationing that allows most people to be dealt with in the free market --- that is, by serving those who are able and willing to pay the price that is asked --- while those who cannot compete in terms of price are offered specified care within prescribed dollar limits. These latter groups are subjected to a means test. The United States rationing system combines the use of pricing, means-testing, and organizational constraints.

One may immediately wonder whether Medicaid, an open-ended program, is an exception to my characterization of means-testing as a rationing device, but of course Medicaid is limitable and limited. Ten years ago, 65 percent of the poor were covered by Medicaid, but today --- following a period of budget stringency --- only 25 percent. It is precisely the relative vulnerability of such a program to legislative shaping and limitation that makes it useful for rationing. Constraining supply and demand in the free market is quite another matter, as we have learned.

I offer you two observations about a two-track health care system. First, however sincere the legislative intention to provide means-tested care of the highest quality, it inevitably turns out badly. This is not true only of health care, of course. No one who has applied for both AFDC and survivors insurance under Social Security, or lived in public and in private housing, or received medical attention in a public clinic for the poor and also as a private patient fails to understand the radical difference in treatment.

The difference is an effect of stigma --- the feeling that means-testing is associated with failure and with being deviant. Officials widely reflect their distaste for their clients, and --- baffling to those who think the poor are so needy or greedy as to be insensitive --- many needy people are reluctant to apply for these benefits.[2]

As means-tested programs grow they become difficult to administer. Suspicion of dishonesty translates into the multiplication of verifications and regulations, some unreasonable and others impossible to administer. On the client side of the table the suspicion grows that this is all a subterfuge for denial. With program deterioration, the staff who are potentially best find other work, exacerbating the difficulties. Impatient with with what appears to be intransigeant administration, the legislature ---state or federal --- writes more and more detailed regulations into law, overwhelming the staff who are involved.

When cost constraints are severe, common sense seems to suggest that means-testing would protect the poor, that is, that it would protect an allocated sum of money for their use alone. With such protection, they should have access to a high quality program. Although plausible, it does not work out like that.

I have just outlined how program administration deteriorates. Among other things, this leads to callous and careless treatment of patients. Apart from that, means-tested programs turn out to be extensively exploitable.

For example, the Reagan administration encouraged states to construct Medicaid-financed HMOs. In the early 1970s, the state of California had contracted with fifty-four prepaid health plans for service to about 300,000 Medicaid enrollees. Within a couple of years, a committee of the California State Assembly concluded that only a hand-full of plans "were providing a quality of care commensurate with the tax dollars they were receiving."[3] A considerable scandal blew up, involving fiscal irregularities and improper links of nonprofit and profit-making organizations, leading first to massive attempts at regulation and then to abandonment of the program. Nevertheless, Arizona went the same route, from competetive contracting for Medicaid-financed group prepayment in 1981 to scandal in 1984. Ohio followed along about a year later.

One may imagine that this is all a giant conspiracy against the poor, but I would not wish to be read like this; the underlying dynamic is impersonal --- political. The success and failure of programs over the years depends on their constituencies. The design of a new program, even one enacted on a wave of reformist sentiment and good will, is only one step in the development of high quality services. More important, in the long run, is that a constituency holds administrators and legislators to high standards of performance and continual improvement of quality and benefit levels. But the constituency of means-tested programs is the poor; and no class of people has less power than the poor. So even well-meaning and well-designed programs deteriorate,if means-tested, while programs with broader constituencies flourish.

One has only to look around to see how this dynamic has operated in the past few years. It is plain that AFDC has been cut back more sharply than Social Security, and Medicaid was cut back but Medicare has been expanded. Social security payments levels automatically adjust to the cost of living; AFDC levels are now one-third lower in real money than a decade ago. Only a few years after Medicaid legislation was enacted, Roger Egeberg, an Assistant Secretary for Health, observed "that the slogan, 'Let's get everybody into the mainstream' should never have been used in connection with Medicaid."[4] Nobody reacted. On the other hand, such a statement about Medicare might have ended the government official's career.

Two Tracks Versus a Single Payer

Means-testing makes sense, if at all, only when there are two or several payers of health care bills. That is, if insurance companies, employers, and patients themselves are paying for medical care, it may seem reasonable to restrict what the government will pay for people defined as needy. If, on the other hand, the government or some agent of the government is paying for everyone, it does not make sense (would seem, indeed, patently discriminatory) to establish different reimbursement scales or different entitlements for people in different financial circumstances. Seen from this point of view, extensive or expanded means-testing is a move to maintain the predominant free market or, anyway, multiple-payer system of care.

The Pepper Commission acts at a moment of health care crisis and widespread public concern which may or could create a watershed in American health care policy. It is worth considering the view that it is the historic moment when we ought to move to single-payer care. I offer you two reasons to do this, one minor, though hardly unimportant, and one major reason.

The minor reason is that a single-payer system is cheaper-a good deal cheaper to administer. In 1985, it is estimated, the cost of administering health care in the United States took 0.59 percent of GNP. Canada, with a single-payer system spent 0.11 percent. I quote the researchers' explanation of this considerable difference:

> On the expense side, all the costs of determining eligibility and coverage [in Canada] are avoided --- everyone is eligible, and for the same benefits. Patients drop out of the payment system entirely, and reimbursement takes place between the public insurer and the provider. There are no marketing expenses, no cost of estimating risk status in order to set differential premiums or decide whom to cover, and no allocations for shareholder profits; the process of claims payments, although not free of costs, is greatly simplified and much cheaper.[5]

Also, of course, Canada's one-payer system requires none of the considerable costs of investigating Medicaid eligibility. An earlier (1983) study estimated that a single-payer system in the United States would save $21.4 billion in the administrative cost of hospitals' and physicians' offices alone.[6]

I devote its own paragraph to the observation that this money saved would have its counterpart in simplifying the lives of patients and physicians --- reducing and, for many people, quite wiping out the endless paper flow and frustration now associated with paying for health care.

This likelihood of considerable saving and simplification is the minor reason for moving to a single-payer system. More important is that a multiple-payer system is, as economists say, an incentive to providers to move back and forth between types of patients and types of services in the quest for the best returns. In this process, one payer is played off against another, with higher costs as the inevitable result. I offer you the simplest example.

Physicians everywhere protest that Medicaid reimbursement is too low, and the A.M.A. estimates that 25 percent of physicians will not accept Medicaid patients. (Personal observation suggests that this figure is too low, but never mind.) Therefore, when a state legislature considers reducing or not increasing the reimbursement rate, it risks losing more physicians and leaving some poor patients without any at all. Even more troublesome, from a cost point of view, some of these patients turn --- have ~~been~~ turned --- to using emergency room facilities, where the costs are of course much higher. This ping ponging of patients, this redefinition of the services that a physician or a hospital renders and search for market niches characterizes a multiple-payer system.[7] As everyone says, we cannot afford it.

Conclusion

The Commission will, I am sure, be much concerned with the inadequate coverage of Medicaid, particularly as there are rising evidences of poor care for pregnant women, infants, and children, and it will be concerned with the millions of moderate-income people who have no insurance coverage. One has not only to think of a system that will work for them, but for the millions more who will be in trouble when and if we experience a recession. Will the health-care-needy then number 50 million? 70 million? And will our system absorb such a shock in the way that Unemployment Insurance, moving automatically from payouts of $2 billion a year to almost $20 billion a year, did in the recession at the beginning of this decade? That is, can we design a system that assures some degree of stability in health care? Or will a shock cause us to scramble unwisely, because hastily, to meet what then will be desperate need?

In answering this and the other questions that the Commission must consider, I urge that you recommend a single-track system, largely not means-tested. I have offered you two reasons. First, a means-tested system will provide mean care and, second, the system that incorporates substantial means-testing will be one in which costs are guaranteed to escalate.

I thank you for the opportunity to present this material.

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Office of Geriatric Medicine
School of Medicine Case Western Reserve University

JUN 28 1989

June 26, 1989

Mary Rose Oakar
Member of Congress
Congress of the United States
House of Representatives
Washington, D.C. 20515

Dear Ms. Oakar:

Thank you for your invitation to present testimony to the Pepper Commission on Comprehensive Health Care on July 6th. Unfortunately, I will not be able to present at the hearing because of previous professional commitments.

I would like, however, to submit the enclosed statement, which is excerpted from an invitational lecture I gave to the American Geriatrics Society on May 12, 1989. It represents a distillation of my present thoughts on this issue, which is one I have been concerned with for over 20 years. I hope we can see some action on this matter in the current Congress.

Sincerely yours,

Amasa B. Ford MD

Amasa B. Ford, M.D.
Associate Dean for Geriatric Medicine

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THE NEED FOR NATIONAL HEALTH INSURANCE

Amasa B. Ford, M.D.

Case Western Reserve University

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The indictment of our present health care financing system is clear. Many studies and proposals have laid it out in detail. To summarize briefly, our system is indisputably fragmented and incomplete, with some 37 million Americans lacking any health insurance; as already noted in regard to the elderly, it presents a veritable minefield of obstacles to access, such as demeaning eligibility requirements and incomprehensible reimbursement procedures; it has also been described as "wasteful and inflationary," and it has defied efforts at quality and cost control because the capacity to regulate has been divided among a multiplicity of interests — government, insurers, hospitals, physicians, and consumer groups — none of which has the power to regulate the whole system.

Do we have to tackle the job of installing national health insurance, and must we go through a painful process of restructuring our entire system? Can't we patch it up and preserve the roughly 60 to 40 public to private mix we now have? Three recent proposals advocate incremental change in our national system of health care financing, to be accomplished by extending existing private insurance and reorganizing public financing in various ways. The Enthoven "Consumer Choice" plan proposes a combination of mandatory employer-provided insurance for full-time workers, purchased from competing insurers, with government-provided insurance for all others.[1] The National Leadership Commission on Health Care, consisting of a number of prominent political, business and professional individuals, has announced a plan that would also continue a major role for private health insurance, purchased through employers; Medicaid would be abolished and uninsured persons would be covered by a federal benefit pool.[2] The third proposal is actually a study, by Rivlin and Wiener of the Brookings Institution, of the question, "who will pay for long-term care?"[3] These authors suggest that there is a large untapped market for private health insurance and other enterprises, but concede, even after examining 30-year projections based on optimistic assumptions about the growth of private insurance, that "it is not realistic to envision the private sector supplanting public funding" and that "the primary source of public sector financing for long-term care should be a social insurance program rather than a welfare program."

If social insurance makes sense for the disabled elderly, why not for the entire population? Such a program would respond to many of the major problems we face now. First, let me make clear that what I am talking about is a unitary system, with central financing and standard-setting and local or regional administration, probably at the state level. The plan I have in mind would be similar to the "Physicians' Proposal" presented by Physicians for a National Health Program, with key features suggested by the Canadian experience, including a planned transition from a public-private mix of financing to largely public financing.[4] It would not be "socialized medicine," since the federal government would not own the hospitals or other facilities nor employ the care providers.

The most important advantage of national health insurance would be that it would provide universal access to health care for all citizens, which we now conspicuously lack. Second, by advance payment to local units that would be responsible for distributing funds, within general guidelines, but responding to local needs, national health insurance would be able to achieve comprehensive coverage of nationally agreed-upon essential services, without glaring omissions, such as adequate home care, that now exist. Third, the vexing task of quality assurance would become more practicable, as, for example, federal funding of nursing homes has already made possible a start toward uniform standards of staffing, performance and, perhaps eventually, outcome. Finally, the experience of Canada indicates that the one demonstrably effective method of controlling national health care costs — an elusive will-o'-the-wisp we have chased for years — is single source payment, combined with a saving of five percent or more in overhead costs associated with a public as opposed to a private insurance system.

Again, is such a change possible in the United States today? Let me assure you, as one who has been advocating national health insurance for more than twenty years, that I have no illusions about the opposition such a proposal will encounter. As Jack Geiger said, when he was establishing prototype neighborhood health centers, "if you think we don't have a health-care system, just try to change it!" Nevertheless, enough may have changed in the last five or ten years to make this logical possibility a real one. In addition to the striking example of Canada, we have information from a Harris poll conducted simultaneously in Britain, Canada and the U.S. showing that Americans are very much more discontented with their health care system than are citizens of the other two countries, and that 61 percent of U. S. respondents would be willing to consider a change to the Canadian system, whereas less than 12 percent of British or Canadians would trade their systems for ours.[5] A very important change, I believe, is now taking place in the attitudes of U. S. physicians, who find that, after years of resisting government medicine, the bureaucratic complexity and constraints of corporate and insurance-company financing interfere more with our practices and with relationships with our patients than anything experienced by colleagues in Britain or Canada. Even the cherished fee-for-service system has been preserved in Canada. Another change is that some recent entrants into the health care financing arena are becoming disillusioned with the manageability of this particular tiger, and at least one large insurance company has withdrawn from the fray. We have heard, just this week, that Chrysler and Ford are ready for national health insurance. Add to these trends the steadily growing political power of the elderly, reinforced, after the turn of the century, by aging baby boomers, and we begin to see a powerful political argument for national health insurance that politicians of today are just beginning to notice. As Winston Churchill is reported to have said, "Americans can always be relied upon to do the right thing after they have exhausted all the other possibilites."[6]

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July 6, 1989

To: Pepper Commission on Comprehensive Health Care

From: Linda Headrick, M.D.
Assistant Professor of Medicine
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Ladies and Gentlemen:

For the 37 million Americans without health insurance and the millions more who are inadequately insured, health care is a luxury which many simply can't afford. Let me give you a couple of examples.

One of my patients is a 32 year-old man who presented with a complaint of abdominal pain. He's a hard-working man with a wife and two children. He works full-time at a local restaurant; his wife works part-time. Neither job provides health insurance benefits. For weeks, he tried to ignore his discomfort, but his wife finally convinced him to consult a physician, despite worries about the bill.

Every decision we made regarding the work-up was affected by concerns about cost. Finally, when we found a mass behind his liver, we were faced with the need for hospitalization and surgery. He asked me if, when the mass was removed, a kidney might also be taken out. He was disappointed when I had to tell him that a donated kidney would not help pay for the operation.

Another of my patients is a woman who spends more than $200 a month for her health insurance. The policy is purchased at an individual rate and provides basic hospitalization, but does not reimburse for doctor's visits, medication or emergency services. She has severe asthma which has resulted in a number of hospitalizations. During one attack, she couldn't even talk on the phone, but refused to call an ambulance or go to the emergency room. She felt she simply couldn't afford it. By the time we finally got someone to bring her into my office, she nearly suffered a respiratory arrest. We barely got her hospitalized in time.

Stories such as these are not unusual. A number of studies have shown that people who must pay for their health care themselves often postpone seeking care or neglect it altogether, sometimes with disastrous results.[1,3,4]

In 1982, the state of California cut its Medicaid costs by redefining the criteria for eligibility. A study of 186 people who lost their Medicaid coverage revealed that in only six months there were three preventable deaths. After discontinuing expensive medications for hypertension and heart disease, two people died, one from stroke, the other from a heart attack. Another man vomited blood for ten days before going to an emergency room; he died of a perforated ulcer. The family reported that he had not sought medical attention because he knew he didn't have the money to pay the bills.[7]

Even patients who have health insurance are experiencing large out-of-pocket costs with the advent of large copayments, excluded services and other limited benefits. As a result, they must decide whether or not to consult a physician or accept recommended treatment on the basis of affordability, whatever the need. This is especially true for Medicare, which pays for less than half the health care costs of the elderly.[5]

I have a particular interest in preventive medicine, but payment for such services is frequently excluded, even by otherwise comprehensive insurance plans. This includes procedures which are well accepted as part of good medical practice. The $75 cost of a screening mammogram might be "saved" in this way, but very high costs result from caring for the significant number of women who eventually develop breast cancer, especially if the diagnosis is delayed. A colleague of mine experienced just such a nightmare with one of his patients. Her breast exam was normal, but he recommended a screening mammogram, following American Cancer Society guidelines. She refused, because of the cost. Six months later she presented with a breast mass; by that time, the tumor had already spread outside the breast.

We physicians work hard to provide the best care we can. We listen to our patient's concerns, perform a careful physical exam, make a diagnosis and recommend options for treatment. Not uncommonly, now, our recommendations may be refused because of the lack of insurance coverage.

However appropriate, diagnostic tests are not helpful if the patient can't afford to have them done. Even the most carefully chosen medication is of no use if the prescription can't be filled. Even the most skilled physician can do nothing for the patient who can't afford to see him in the first place.

Shifting part or all of the burden of payment to the patient (or "beneficiary") has become a common tool for cost-containment.

As this occurs, medical care becomes a commodity which must be purchased like any other. Regardless of need, the rich get more, the poor get less. The rest of us fall somewhere in-between.

Access to medical care should not be determined by the ability to pay. Until universal access is guaranteed by universal health insurance coverage, access will be denied to many. I urge the Commission to consider strongly the proposals of the Physicians for a National Health Program[2] and the Northeast Ohio Coalition for National Health Care (testimony to be given in this forum by Dr. Ken Frisof).

Thank you.

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THE CLEVELAND CLINIC FOUNDATION
One Clinic Center 9500 Euclid Avenue Cleveland, Ohio 44195-5244
A National Referral Center An International Health Resource

The Mellen Center / U10
216/444-6800

MEMORANDUM

To: U.S. Bipartisan Commission on Comprehensive Health Care

From: John P. Conomy, M.D.
Chairman, Department of Neurology

Deborah M. Miller, LISW
Coordinator, Social Work Services
Mellen Center

Date: July 3, 1989

Re: Public Hearing, July 6, 1989, Cleveland, Ohio

Multiple Sclerosis is a chronic disabling neurological disease that affects 250,000 people in the United States. Those affected by the disorder are usually in their twenties to forties when the disability it causes begins. About two thirds of people with MS suffer some combination of difficulty in their walking ability, vision, hand function, or bowel and bladder control as well as cognitive dysfunction. These problems produces long term care needs, including health care and social services, that will endure for forty to fifty years. Although greatly in need of such services, most people with MS have very limited access to long term care. This occurs for two reasons. Many lack health insurance benefits to pay for such care. Also, there is limited availability of comprehensive physical and psychosocial rehabilitative treatments.

The Cleveland Clinic Foundation has provided care to 3,000 of the estimated 33,000 people with MS who live in the surrounding 7 state region. Of these, 1,300 patients and their families receive care for their disorder at the Mellen Center for Multiple Sclerosis Treatment and Research. This facility is a specialty clinic that is part of the Department of Neurology at the Cleveland Clinic. Its existence has been made possible due in large part to the benevolence of the Edward and Louise Mellen Foundation. MS patients and their families have helped establish the need for intense medical, psychological and social assistance produced by this disease through their participation in this comprehensive care center. Similar needs have been identified at other comprehensive care facilities that belong to the international Consortium of Multiple Sclerosis Centers.

This chronically disabled young adult population, it has been repeatedly demonstrated at the Mellen Center, is significantly underinsured but seldom included in considerations of the need for comprehensive long term care.

Some reasons that this group is underinsured include:

FOR THOSE WHO ARE UNABLE TO WORK

* when no longer able to work, many receive neither disability income or group health insurance from former employers

* if approved for Social Security Disability after becoming unable to work. Medicare Insurance becomes available only after a delay of 24 months, leaving many disabled individuals uninsured during the intervening two years

* because of the complex nature of the disease, many individuals who in fact are unable to sustain gainful employment are determined ineligible for Social Security Disability. They will remain ineligible for Medicare benefits until of retirement age.

* a recent communication with staff at the Health Insurance Institute of America confirms that there is no private insurer that writes a "medigap" policy for people under 65 years of age

* many people with multiple sclerosis are unable to purchase individual private policies or be included in family members' work related group plans because of prohibitive cost or "preexisting illness" exclusionary clauses

FOR FAMILY MEMBERS

* in those cases when the family member disabled for work by MS was the source of health insurance for the family, that entire family becomes uninsured

* in cases when the "well spouse" attempts to reenter the work force (in addition to providing care to the disabled family member), employment is often restricted to part-time work or with small businesses that are recognized by the Commission to have limited health insurance coverage

- there have been reports of "well spouses" being denied their own health insurance because of the potential hazard to health that occurs with the responsibility caregiving to a disabled family member

Although there are many people with MS who are able to work either full time or under some restrictions, it is difficult for many to engage in such employment. Some reasons for this include:

FOR THOSE WHO HAVE MS

- among those who have obtained medicare or medicaid entitlement, there is an understandable reluctance to attempt employment (which for the above stated reasons is not likely to offer a health insurance benefit) and risk loss of insurance benefit through government programs

FOR EMPLOYERS OR POTENTIAL EMPLOYERS

- because of concerns that many employers have about meeting the cost of health insurance or worker compensation liability for potential employees who are disabled, they restrict themselves hiring members of this population

Some reasons that this population is not adequately served by the long term care system include:

FOR ALL DISABLED OR IMPAIRED INDIVIDUALS

- non-institutional and non-medical services are uncompensated by virtually all health insurance providers. These uncovered services include custodial nursing home care; respite care; personal attendant care; rehabilitative care that is considered "maintenance" rather than "therapeutic"; out-patient psychiatric or psychological services

FOR WORKING AGED DISABLED ADULTS

- there are some in-home services provided through federal and local programs to older Americans that are dependent on age eligibility. For this reason people under 65 who have care needs similar to their elder counterparts do not have access to programs like home health aid assistance, chore service, or home meal delivery programs.

These working aged adults require the special attention of the Pepper Commission on Comprehensive Health Care. Current health care legislation, including that passed in the last Congress, does not address the long term and catastrophic needs of these persons. They are neither disabled children nor elderly. They are adults in the prime of their lives who have dwindling ability to care for themselves. The needs of persons with multiple sclerosis, as well as others like them with varieties of connective tissue and neuromuscular disease, with malignancies and accidental injuries need to be included in the comprehensive considerations related to the economic support of health care for Americans.

Testimony for The Pepper Commission -

Ameritrust Tower Auditorium July 6, 1989
Cleveland, Ohio 44114 - Cynthia Weir - Health Care C.H.
Cuyahoga County League of Women Voters

Dear Congresswoman Oakar and The Pepper Commission

This opportunity to speak on the subject of small business obligations to pay the costs of Health insurance for their employees is both timely and important. As an enthusiast for Universal National Health Care I see this problem as the major obstacle to its passage unless the plan protects both employee and employer. Small Businesses are growing space and are the best hope for the future of Cleveland.

The Hagan Bill H.B.425 provides Universal Health Care for Ohio. It's to be funded by an 80% payroll tax, a 1% wage tax, 2% on interest and dividends and 10% increase in "SIN" taxes.

A study has shown the average person thinks 30.00 a year is the right amount for health coverage. costs close to $1600 are presently more like it. We actually are spending 11.5% of our G.N.P. on health care compared to Canada's 6%.

So much of this goes for establishing eligibility and duplication of paper work that once we switched we could easily afford to subsidize these small beauty shops, exercise classes, house cleaners etc. This would mean their children would be immunized (only 1/2 now are) and they could get good preventive care for themselves with no fear of going broke.

Health care is a right, not a privilege.

Respectfully submitted,

Cynthia E. Weir

July 3, 1989

The Honorable Mary Rose Oakar
215 Superior Avenue, Room 523
Cleveland, Ohio 44114-1281

Dear Representative Oakar,

The enclosed written testimony is being submitted on behalf of the Cystic Fibrosis patient and their families concerning the health-insurance problems for the elderly and disabled persons. Unfortunately, we will not be able to attend your **very** important meeting on July 6, 1989.

On behalf of **all** disabled persons, we would like to THANK YOU for your efforts on this matter.

If we can be of additional assistance in this matter please feel free to contact us.

Sincerely,

Mal Bernbaum
Madeline Bernbaum
2583 Ashurst
University Heights, Ohio 44118
(216) 932-2420

R. Shaltens
Richard Shaltens
2149 Richland Avenue
Lakewood, Ohio 44107
(216) 226-0242

STATEMENT FOR

US BIPARTISAN COMMISSION

on

COMPREHENSIVE HEALTH CARE

by the

Cystic Fibrosis Foundation
Cleveland, Ohio

July 6, 1989

The Cystic Fibrosis Foundation (CFF) represents a population of approximately 30,000 disabled people in the United States. Cystic Fibrosis (CF) is an congenital inherited disease. Over 1,000 patients with Cystic Fibrosis (CF) are being treated in Ohio. As with people with other chronic diseases, the CF patient finds that health insurance is both unaffordable and in many cases unavailable.

The majority of CF patients are protected by their parents health insurance. However, when they reach adulthood this coverage ceases and in a number of instances these individuals are unable to secure their own insurance coverage. This is because of their high risk medical status (a preexisting chronic disease) and the extremely high cost of insurance. This is adding to the already increasing population of the "working uninsured".

This CF population represents a group of people who rely on an intense medical regimen. They use daily antibiotics and digestive enzymes to stay alive. They also are hospitalized frequently for more intensive therapy depending on their state of health; it can be multiple times per year for period of two (2) to three (3) weeks, and in a few cases hardly ever.

Despite the disparity of the disease the CF adult patient continues to lead as normal a life as possible. The majority of the adult CF patients are productive citizens, working and raising families, leading as full a life as their health permits. It is tragic that in many instances it is the sickest suffering life threatening bouts of the illness who are without hospitalization. They have an added concern regarding the payment of services they must have to live. In some cases they wait too long to obtain these services because they cannot pay. This results in increased sickness and longer hospitalizations and further deterioration of their already fragile health.

We need to assist both the elderly and disabled persons in resolving the national problem of uninsured high risk subscribers. Why should our society victimize those who are in greatest need and the least able to protect ourselves???

Contacts: Madeline Bernbaum (216) 932-2420 or Richard Shaltens (216) 226-0242.

Testimony of Dominic D. Gianasi, President, Federation of Retired Workers
Chairman, Social Action Committee of the Jewish Community Center
Board Member, Ohio Council of Senior Citizens
V.P., Workmen's Circle Branch of the National Council of Senior Citizens

Members of the Commission on Comprehensive Health Care, Members of OUR ORGANIZATIONS, FRIENDS AND LADIES AND GENTLEMEN:

WE ARE THE RICHEST COUNTRY IN THE WORLD. WE HAVE THE BEST MEDICAL-SCIENTIFIC RESEARCH, THE MOST ADVANCED MEDICAL TECHNOLOGY, THE BEST EDUCATED CORE OF HEALTH PROFESSIONS, AND THE BEST EQUIPPED HOSPITAL AND OTHER HEALTH FACILITIES. THE AMERICAN MEDICAL ASSOCIATION AND THE ACADEMY OF MEDICINE KEEP REMINDING US OF THESE FACTS. IF ALL OF THIS IS TRUE, THEN WHAT IS THE PROBLEM? THE PROBLEM IS THAT ALL OF THESE WONDERFUL ADVANCES ARE NOT USED ON MILLIONS OF OUR PEOPLE WHO NEED THEM. WE ARE NOT GETTING FULL VALUE FOR OUR HEALTH DOLLARS. WE ARE SHORT ON PERFORMANCE.

WE SPEND MORE THAN TWICE AS MUCH PER CAPITA FOR HEALTH CARE AS THE AVERAGE PER CAPITA THAN THE OTHER MAJOR INDUSTRIAL COUNTRIES, BUT IN INFANT MORTALITY, A WIDELY USED MEASURE TO COMPARE HEALTH STATUS, WE RANK 20TH AMONG TWENTY INDUSTRIALIZED COUNTRIES. A FEW YEARS AGO WE RANKED 16th--WE ARE FALLING FURTHER BEHIND. EVEN TAIWAN AND SPAIN HAVE BETTER RECORDS THAN WE DO. ALL OF THESE NATIONS HAVE SOME FORM OF NATIONAL HEALTH CARE.

HOW DO WE COMPARE WITH THE REST OF THE WORLD IN TERMS OF QUALITY?

* 12 COUNTRIES DO BETTER PREVENTING CANCER DEATHS;
* 17 COUNTRIES HAVE LONGER LIFE EXPECTANCY;
* 26 COUNTRIES HAVE LOWER CARDIOVASCULAR DEATH RATES;
* A RECENT REPORT BY THE ROBERT WOOD JOHNSON FOUNDATION FOUND THAT ONE MILLION AMERICANS ANNUALLY ARE DENIED HEALTH CARE BECAUSE THEY CANNOT PAY FOR IT; AN ADDITIONAL 14 MILLION DO NOT EVEN SEEK CARE THEY FEEL THEY NEED BECAUSE THEY CANNOT AFFORD IT;

* ACCORDING TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, ABOUT TWO-AND-A-HALF MILLION FAMILIES ANNUALLY FACE CATASTROPHIC OUT-OF-POCKET HEALTH CARE EXPENSES EXCEEDING $3,000:

* A CHILD OF 5MONTHS LIVING IN WASHINGTON, D.C. JUST 5 MILES FROM THE CAPITAL, HAS LESS CHANCE OF REACHING AGE 1YEAR THAN A 5 MONTH OLD CHILD LIVING IN SOME THIRD WORLD COUNTRIES.

* AMERICA RANKS FIRST IN THE WORLD IN THE GROSS NATIONAL PRODUCT AND IN THE SOPHISTICATION AND SCOPE OF ITS MILITARY TECHNOLOGY, BUT OTHER COUNTRIES HAVE BETTER RECORDS IN TAKING CARE OF THE HEALTH OF ITS PEOPLE. THE DIFFERENCE IS THAT THEY HAVE SOME FORM OF NATIONAL HEALTH CARE AND WE DO NOT.

THE DOCTORS IN THE AMERICAN MEDICAL ASSOCIATION AND THE ACADEMY OF MEDICINE CAN BRAG ABOUT WHAT FACILITIES THEY HAVE BUT THEIR PERFORMANCE WILL BE JUDGED BY HOW THEY USE THAT TECHNOLOGY.

CRITICS OF NATIONAL HEALTH, ESPECIALLY THE INSURANCE COMPANIES, ARE OF THE OPINION THAT PRIVATE ENTERPRISE IS MORE EFFICIENT, FAR LESS GIVEN TO RED TAPE, AND LESS RIGID. A LOOK AT THE ACTUAL OPERATION OF PRIVATE HEALTH INSURANCE, HOWEVER, LEADS TO QUITE A DIFFERENT POINT OF VIEW. THERE ARE MORE THAN 1000 COMPANIES PROVIDING HEALTH INSURANCE IN THE UNITED STATES. THEY OFFER A SMORGASBORD OF POLICIES, EACH WITH ITS LIMITATIONS AND VARYING BENEFITS--OFTEN DIFFICULT TO EVALUATE. BLUE-CROSS/BLUE SHIELD OFFERS A TOTAL OF 65 DIFFERENT PLANS. ALL INSURANCE COMPANIES OFFER A MULTPLE OF PLANS. UNDER A NATIONAL HEALTH CARE PLAN THERE WOULD BE ONLY ONE PLAN TO FOLLOW.

WHEN IT COMES TO EFFICIENCY, WE CAN COMPARE BENEFITS PAID OUT BY PRIVATE INSURANCE COMPANIES AND THOSE PAID OUT BY NATIONAL GOVERNMENT AGENCIES. PRUDENTIAL PAYS OUT 77% OF PREMIUMS IN BENEFITS. $3075 MILLION IN PREMIUMS, $2356 MILLIONS IN CLAIMS PAID. THE 23 PERCENT BALANCE GOES TO SALES PERSONNEL, ADVERTISING AND PROFITS TO

INVESTORS. AETNA INSURANCE COMPANY SHOWS A BENEFIT-TO-PREMIUM RATIO OF 84%, METROPOLITAN LIFE 73%; TRAVELERS 81% AND MUTUAL OF OMAHA 77%. UNION FIDELITY LIFE'S MEDICAL SUPPLEMENT INSURANCE, WHICH USES ACTOR DANNY THOMAS AS ITS FREQUENT ADVERTISING VOICE OF TV (AND THAT HAS A HIGH SALES COST), PROVIDES BENEFITS RATIO OF ONLY 42.6%, LESS THAN HALF THE PREMIUM PAID IN. THERE ARE 5 OR 6 OTHER INSURANCE COMPANIES OF THIS TYPE THAT SPEND A LOT OF MONEY FOR TV ADVERTISING THAT PAY OUT LESS THAN 50% OF PREMIUMS COLLECTED, IN BENEFITS.

THE NON-PROFIT BLUE CROSS AND BLUE SHIELD IN CONTRAST HAVE A BENEFITS RATIO OF 90.4%, ON A YEARLY BUSINESS OF $41.5BILLION. THE OVERHEAD IS BUT 9.5%--THEIR OPERATION IS NON-PROFIT. BLUE CROSS/ BLUE SHIELD OF OHIO ARE PROBABLY PAYING OUT LESS IN BENEFITS BECAUSE OF THE LARGE AMOUNTS OF MONEY THEY'VE BEEN SPENDING FOR ADVERTISING TO GET THE LEGISLATION THEY'VE WANTED AND IN THEIR BATTLE WITH THE HOSPITALS.

ON THE OTHER HAND, MEDICARE, ADMINISTRATED BY THE FEDERAL GOVERNMENT HAS A BENEFIT RATIO OF MORE THAN 95%. HANDLING AN ESTIMATED $80,000,000,000 IN CLAIMS IN ONE YEAR. (IT HAS LITTLE OF THE SALES AND ADVERTISING EXPENSES OF THE OTHERS AND SUB-CONTRACTS ITS CLAIMS PROCESSING TO BLUE CROSS/BLUE SHIELD. ITS ENTIRE OVERHEAD IS LESS THAN 5%.

THE PRIVATE ENTERPRISE MODEL OBVIOUSLY RETURNS THE LEAST BENEFITS FOR PREMIUM PAID. NON-PROFIT BLUE CROSS/BLUE SHIELD DOES CONSIDERABLY BETTER. FEDERALLY ADMINISTERED MEDICARE--CONTRACTING OUT CLAIMS PROCESSING--DOES EVEN BETTER. THE SOCIAL SECURITY ADMINISTRATION, FULLY FEDERAL DOES BEST OF ALL ON A MERE 1.5% ON OVERHEAD. 98.5% IS PAID OUT IN BENEFITS. THIS SHOULD BE OUR MODEL.

A PROPER NATIONAL HEALTH PLAN MUST:

CONTAIN THE RECOMMENDATIONS OF THE NATIONAL COUNCIL OF SECIOR CITIZENS." AT A MINIMUM, THE BASIC PRINCIPLES OF A NATIONAL HEALTH PLAN MUST INCLUDE: 1) COMPREHENSIVE COVERAGE FOR EVERY AMERICAN:

2) COVERAGE FOR LONG TERM CARE; 3) MANDATORY ASSIGNMENT FOR EVERY PHYSICIAN AND FOR ALL PATIENTS; 4) STRONG COST CONTAINMENT PROVISIONS DESIGNED TO REDUCE THE FINANCIAL BURDEN OF PAYING FOR HEALTH CARE SERVICES."

NATIONAL HEALTH CARE IS AN IDEA WHOSE TIME HAS COME. IT IS TIME FOR A CHANGE.

THANK YOU.

TESTIMONY TO THE U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

Thursday, July 6, 1989

Ameritrust Auditorium, 9th & Euclid Avenue
Cleveland, Ohio 44115

My name is Hazel C. Callahan and I am a quadparalegic. I am 54 years of age. My condition occured in 1983 after surgery to remove a tumor from my spinal cord.

I was a teacher in the Cleveland School System for 18 years. My symptons began in 1977 and I was forced to retire in 1978. Presently I am living independently with the assistant of a temporary care-giver. I receive $1300.00 per month in disability payments from the Cleveland School Board. The cost of the care-giver is $500.00 per month. My rent is $410.00 per month. The cost of utilities -electric and telephone - is $100.00 monthly. I provide food for myself and the care-giver which is approximately $200.00 monthly. I also must purchase diapers, medicine and other personal needs. You can see that the $1300.00 barely covers my needs.

I would like to continue to live independently but it is hard to find someone to live in on a seven day-24 hour basis at the cost I am able to pay.

My father has helped me financially and physically, but he is now limited in the physical and financial care. He is 82 years and recently underwent cataract surgery and more surgery is planned.

My family has talked of putting me in a nursing home but since I am not sick, just disabled, I prefer to continue to live independently as long as possible. The cost of a nursing home, even the most inexpensive one, would cost $1500.00 monthly - more than I am now receiving from disability payments. I am not eligible for Social Security because the School Board does not use the Social Security System. I am not eligible for Medcaid or Medicare because of my age. I applied for Welfare but did not qualify because of my disability income.

I have inquired about professional live-in attendants but I cannot afford their prices. My present care-giver is only temporary and when she has to be away I depend on family members and friends. I don't want to abuse their love and concern for me.

I was a productive citizen when I was able to work. I paid taxes and served my country and community well. I am now asking for your help in providing me with some financial assistance to insure that I may continue to live independently and with as much dignity as possible.

I thank you for this hearing and pray that I and others like me will be helped.

On the following page are some comments from the lady who is temporarily caring for me.

Hazel C. Callahan
4441 Granada Blvd.
Warrensville Hts., Ohio 44128

TESTIMONY TO BE PRESENTED TO THE

UNITES STATES COMMISSION ON COMPREHENSIVE HEALTH CARE

AMERITRUST BUILDING
900 EUCLID AVENUE
CLEVELAND, OHIO 44114

Helene R. Stone
Associate Director
Neighborhood House Association
1536 E. 30th Street
Lorain, Ohio 44055

SENIOR NEEDS FOR HOUSING ALTERNATIVES

I am Helene Stone, Associate Director of Neighborhood House Association, a large multi-service private non-profit agency in Lorain County, adjacent to the Cleveland Metropolitan area. The Agency targets services to low income, minority and frail elderly populations throughout the county. Many of the clients served are low income frail elderly. Services which the agency provides include home delivered, congregate meals and housekeeper services funded by the Older Americans Act through the Western Reserve Area Agency on Aging: an alternative housing program for frail seniors in a metropolitan housing unit; and a planned intergenerational shared living home in Oberlin, Ohio.

The following is a discussion of senior citizen needs for housing alternatives, including an example of an innovative project called Lakeview Assisted Living Center in Lorain which is an affordable model for frail low income seniors:

> The expanding elderly population throughout the nation is presenting a challenge to organizations involved in social planning and service provision. Numerous studies and planning projections indicate that the number of persons age 60 plus proportionate to the rest of the population will increase dramatically within the next twenty to thirty years. Within this population group, the number of persons age 74 plus will increase at an even greater rate. In Lorain County, we have seen an increase of persons age 60 plus from 26,560 in 1970 to 34,501 in 1980. The Lorain County Planning Commission projections anticipate that by 1990 the elderly population in the county should reach 43,400.
>
> Frank Spink of the Urban Land Institute, a "think tank" for

national urban planning, marks 1980 as a "watershed year" in which the percentage of U.S. households aged 65 or over topped the percentage of U.S . households aged 30 or less (Spink, 1983). Katherine Warner, a professor of architecture and planning at the Institute of Gerontology, University of Michigan, points out that the number of elderly persons living alone has increased significantly, more than three times as fast as the increase in the elderly population itself (1983). Warner also indicates that in 1980, the median income of households headed by older persons as $12,881, only 57 percent of the median income ($22,548) of the households headed by persons younger than 65.

At least 40 percent of homes owned by elderly persons are at least 40 years old and in need of significant repairs. Declining physical ability to take care of maintenance and repair problems often "trigger" a decision to make a housing change.

It is estimated that chronic illnesses affect nearly 85 percent of all elderly persons not in nursing facilities. The most chronic conditions are arthritis, heart disease, hypertension and diabetes. McKinney and DeVyver of Duke University have identified a number of factors which provide motives for residential changes in older persons. They include reduction of family size, death or institutionalization of the spouse, loss of kin or neighbors, physical changes in neighborhood, general deterioration of the structure and forced dislocation.

It is apparent from the information provided above that there is a need for safe, affordable, accessible housing for older persons and the need for housing is rapidly increasing.

Frank Spink has stated that "developing appropriate responses the the housing needs of a maturing population will be the challenge of the 1980's and 1990's, requiring a rethinking of both housing design and the structural form of communities" (1983), p. V).

Housing alternatives which provide supportive services and allow some level of independent living provide an answer for older persons who wish to remain in their communities as their physical and mental facilities decline.

Shared Living is an innovative approach to housing seniors. James Herman, Georgia Anetzberger and Nancy Beheim described the concept in an article called "Use of Existing Large Homes for Shared Living" (1983, p. 164). They point out that this type of living has been called by various names including "communal living", "share-a-home", and "group housing." It occurs when a group of three of more older persons live together in independent housing for the purposes of social contact, mutual support and assistance and pooled household expenses. Integral to this concept is the availability of assistance for the seniors with meals, housekeeping chores and transportation.

Shared Living projects began to be developed in Ohio in 1978. By 1984, the Ohio Department of Aging offered funding to assist in the development of shared living models as alternative living situation for seniors. The projected Oberlin Intergenerational model adds a group of young college students interested in living with older people to the shared living environment. This idea was initiated by Jeanne Butts, age 84, the Director of Oberlin Office on Aging; Bob Thomas, age 84, a leader in aging program development at local and state levels and David Clark, Director of Capital Ventures of Oberlin College. These three community leaders have worked closely with Oberlin residents, the Lorain County Human Services Department and Neighborhood House Association to develop support for the intergenerational group home concept.

The Lakeview Assisted Living Center is a program managed by Neighborhood House in cooperation with the Lorain Metropolitan Housing Authority. Initiated in 1984, with the assistance of a start-up grant from Nordson Foundation, the program is a model for the provision of assisted living services to low income elderly in subsidized public housing. Geared to meet the needs of those older persons who are frail and may need personal care, the services include the following: an individual secure apartment equipped with an emergency call system, three meals every day, monitoring by a resident manager, escort/transportation for medical appointments and prescription pick-up, recreational and social activities, access to housekeeping-home health services as needed.

Costs to the client are $300 per month for the service plus the rent determined according to the local housing authority guidelines. One of the ways costs are reduced is the use of the Title IIIC meals at noon, five days a week. The balance of the meals are provided by cooks who are part of the Lakeview Assisted Living Center staff.

In July 1985, the center was featured in the HUD Journal of Housing. (Copy of article by Housing Authority Director Schroeder attached). In January 1987, the Lakeview assisted Living Center received the United Nations International Year of the Shelter for the Homeless Award. Several housing authorities consulted Neighborhood

House and the Lorain Housing Authority regarding the development of a similar project. Knoxville, Tennessee Housing Authority and St. Paul, Minnesota were particularly interested. As the model has received greater attention, numerous contacts with universities and housing authority staff have been made.

In summary, as the elderly population expands, it will be increasingly important to provide alternative living options for low income elderly. Creative use of public housing and available housing stock to provide supportive living arrangements will help to provide alternative choices to the frail, aging population.

In order to expand housing options available to low income older persons it will be necessary to:

1. Provide incentives to local housing authorities to develop assisted living centers in public housing.

2. Expand subsidized congregate and home delivered meals for older persons; either through the Older Americans Act or through other federal legislation to meet the nutritional needs of the elderly.

3. Designate a portion of those subsidized meals to be made available to non-profit agencies providing supportive services in subsidized low income housing for the elderly.

Testimony
of
The National Council on the Aging, Inc.
and the
National Institute on Adult Daycare
Before The
Bipartisan Commission on
Comprehensive Health Care
Cleveland, Ohio
July 6, 1989

Presentation to the
Bipartisan Commission on Comprehensive Health Care
July 6, 1989

Congresswoman Oakar and other Commission members, I am Joan Scharf, Director of Menorah Park Adult Day Health Care Center, one of the oldest, largest and most comprehensive adult day care centers in the United States. I am representing The National Council on the Aging's National Institute on Adult Daycare. The National Council on the Aging. Inc., founded in 1950, is a national nonprofit organization. Its membership includes individuals, voluntary agencies and associations, business organizations and labor unions united by a commitment to the principle that the nation's older people are entitled to lives of dignity, security, physical, mental and social well-being, and to full participation in society. Ohio's adult day care centers are organized into the Ohio Association of Adult Daycare representing 65 adult day care centers serving 1,500 participants per day.

The National Institute on Adult Daycare is the only organization composed of professionals working to develop and expand the adult daycare field to advocate for those who rely on adult day care for daily and continuing support and care, and for those working to ensure that adult day care is of the highest quality, based on solid standards of excellence and available throughout the nation.

I am very pleased to be here today and have the opportunity to testify on behalf of adult day health care and its benefits to older people and their families/caregivers.

Though the majority of older persons can be expected to live out their lives with minimal difficulty, there is an alarming increase in the numbers of older people who have major disabilities and chronic diseases. There are well documented statistics, which I am sure the Bipartisan Commission has on record, about the increasing number of people over age 75, persons most likely to be "at risk" and more susceptible to impairments. These statistics--coupled with the high cost of institutional care, the long waiting lists for nursing homes, and the large numbers of inappropriate and premature institutional placements--have mandated the development of cost effective, yet high quality, community-based care for the nation's frail and impaired adults.

During the past ten years, adult day health care has developed to meet the needs of this population. It provides a variety of services and activities that enable impaired adults to remain in their homes and communities. As the term implies, adult day health care is a program of care during the day in a protective group setting. It is an innovative and effective way to organize and blend traditional health and social services for impaired adults. However, although day health care is not a new concept, it is still not an integral part of long term care in many areas. First introduced in the early 1960s, it has been slow to develop--largely due to the lack of stable reimbursement sources. In 1973 there were only 15 programs nationwide; today however, there are over 2,000 serving approximately nearly 100,000 persons daily. This growth has been largely a grassroots movement, developing without any national initiative (other than that provided by NCOA) or coordinated funding source. In fact, it has occurred in spite of a public policy that has long favored institutional care.

Programs have sprung up throughout the country, under the auspices of a variety of sponsoring organizations, both private and public. The majority are nonprofit. They are located in churches, hospitals, multipurpose senior centers, elderly housing projects, nursing homes, and homes for the aged. The average per diem cost for adult day health care based on a national survey done in 1986 is $27-$31--much less than the cost of other forms of long term care. At present, most programs rely on multiple funding sources which include Title XIX (Medicaid), Title XX (Social Services), Title III (Older Americans Act), client fees, foundation and philanthropic support. A few receive reimbursement through private insurance carriers and, in some instances, the Veterans Administration is reimbursing veterans for the service. At present, there is little local funding from counties for adult day health care and what exists is mostly in-kind support.

Most adult day health care programs are staffed by a multidisciplinary team. Though programs vary in focus and resources, it is generally agreed that staff should include or have available as consultants the following: nurses, social workers, occupational therapists, speech therapists, physical therapists, and recreation therapists. Physicians also play an important role in working with center staff to develop an appropriate individual plan of care.

Though adult day health care programs are group programs, they are also tailored to meet each participant's needs and preferences. Adult day health care offers an individual plan of care, based on a person's functional assessment. Each participant is provided the opportunity to socialize and participate in health, social, recreational, and therapeutic activities that maximize his/her abilities and independence. Probably the most important aspect for helping the individual is the atmosphere of expectation. It consists of respect for the individual's latent strengths, the belief that some improvement is possible and the provision of an opportunity to try.

Those most likely to benefit from participation in adult day care programs are persons who would otherwise be substantially homebound or institutionalized. Recent state evaluation reports document these benefits. Adult day health care assists the participant, his/her family caregiver, and is a cost effective and efficient method of health care delivery.

FOR THE PARTICIPANT

Adult day health care restores and rehabilitates someone to their highest level of functioning. Every center can testify to the small miracles that occur such as the person who had a stroke who learns to walk again with the proper therapies, nursing management, personal care attention and enjoyment found with just being with others. Others are maintained at their highest level of functioning, thus preventing further decline and debilitation.

FOR THE CAREGIVER

The benefits of adult day health care to family/caregivers have become increasingly recognized. Families provide 80 percent of all health care for the elderly, and recent business surveys are identifying that as many as 35 percent of employees are providing some form of caregiving to their older family members. Research is showing that caregiver burnout is the most significant factor in nursing home placement, not the physical and health status of the older person. Family resources are not unending. Fatigue, lack of personal time, mobility of family members, financial costs, and the need or desire of caregivers to seek paid employment often lead to stress and eventual breakdown in the family's efforts. Adult day health care is a valuable service, as it provides respite to the caregiver and relieves stress, enabling the caregiver to continue providing care, and helps employee productivity.

FOR THE GOVERNMENT

By utilizing the benefits of a group setting, adult day health care costs less than the one-to-one provision of home health care. For example, adult day care costs approximately $30 a day in Ohio, much less than one hour of physical therapy session in the home. The center package at $30 also includes a full day of meals, nursing care as needed, personal care services, including bathing, recreation and transportation. Evaluation reports from other states such as Hawaii, New Jersey, and Massachusetts also indicate state satisfaction with adult day health care's costs and effectiveness.

If adult day care is to continue to expand to meet the changing health needs of the ever-growing elderly population, the federal government must play a role. NCOA/NIAD urges that the Bipartisan Commission on Comprehensive Health Care recommend to Congress that it:

1. Include adult day care as a free-standing full service --an equal partner with home and institutional care--in all comprehensive long-term care legislation. A long-term care system must include home, community and institutional care. Adult day care is a vital element representing community services.
2. Enact H.R. 990 (Panetta, et.al.)and S.524 (Bradley and Heinz) which make adult day care a Medicare benefit. This could be a first step in an incremental approach towards a long-term care system.

   S.524 establishes eligibility and service requirements, certification standards developed by Department of Health and Human Services with consultation from NCOA/NIAD, eligibility determination by state pre-admission or Medicaid long-term care agencies and surveys by the appropriate state agency. CBO estimates initial year costs to be $100 million to grow to $1 billion in five years. These costs are offset by savings in other government funds, i.e. Medicaid.

3. Encourage the inclusion of adult day care in long-term care private insurance policies. A recent Health Insurance Association of America report noted that of the 14 new long-term care policies developed since 1988, six (43%) include adult day care.

NCOA/NIAD believes Medicare funding for adult day care is required for the following reasons:

1. Medicare coverage for adult day health care will make it accessible to those low and middle income persons who do not meet the income eligibility requirements for Medicaid or Social Services Block Grant but cannot afford to pay for these services. It also will help prevent the older person from becoming impoverished before he/she becomes eligible for care.
2. Medicare is a trend-setter for private health insurance coverage. Medicare coverage will point the way towards inclusion of adult day health care in long-term care policies.
3. Medicare funding will result in the development of national certification standards and a method of quality assurance. Although NIAD and NCOA have developed national standards, they are generic and

voluntary. It would be helpful to the field to ensure that centers provide quality programs through a national certification process. NCOA/NIAD would be pleased to work with the Health Care Financing Administration not only in developing standards for certification but also procedures and training for state employees.

4. Medicare reimbursement would increase center resources, thus enabling those centers who wish to qualify for certification to add additional services if needed.

Congress has already recognized the increasing importance of adult day care through the inclusion of adult day care centers as participants in the Child Care Food Program of the U.S. Department of Agriculture and its mandate for a national adult day care survey (information has been collected and is now being analyzed) in the Catastrophic Care Act of 1988 and recommendations for Medicare standards (Section 208, Medicare Catastrophic Act of 1988).

NCOA/NIAD makes these recommendations for medicare coverage for adult day care based on its principles for a national long-term care system. NCOA supports a national long-term care system that will provide comprehensive services to enable persons with physical and mental impairments to remain, when possible, in their homes and, when necessary, to obtain appropriate institutional care. Eligibility for services must be based on impairments and not on arbitrary demarcations of age or income.

Financing should be based on a social insurance model, including equitable and affordable cost sharing. A comprehensive national long-term care system should incorporate the following principles:

1. Shared Responsibility

   Access to appropriate and affordable long-term care is a right of all Americans. While assuring such access to quality and comprehensive long-term care services is a responsibility shared by the whole society, clear roles must be accepted by government.

   The federal government has a fundamental role in guaranteeing access, setting basic quality standards and, in large measure, financing that care. State governments, under federal guidelines, have responsibility to share in costs and for operational aspects of the system, including selection of providers, assurance of needed transportation services, and monitoring quality and compliance. Responsibility to assess eligibility and needs under consistent statewide standards and to monitor the provision of services must reside with local public or private entities.

   This system must encourage those who require care or who are at risk to engage in programs of self-care and in activities which can enhance recovery and wellness. Such a system must also ensure support for informal caregivers and account for their participation in care decisions.

2. Eligibility
The design of eligibility and assessment standards and care plans should be free of limiting age and income factors. Such plans and standards must be keyed to functional impairments, including medical and psychological elements, and not to specific diseases in determining who is to be served.

3. Financing
The financing of a comprehensive long-term care system should reflect social insurance principles, with the burden shared through federal payroll and income taxes, state and local resources, and modest copayments by users of services. Such financing could incorporate private long-term care insurance and copayments based on sliding fee-scale principles. The current system of public financing requiring the exhausting of life savings to qualify for services must be ended.

4. Supportive Environments
All persons requiring long-term care have an inherent right to care in the least restrictive health and social service setting. That environment is preferably

and practically the home and the neighborhood. Where necessary, the setting may be institutional but with a home-like atmosphere, supportive of both care recipients and caregivers.

5. Housing

A comprehensive long-term care policy must include support to provide an accommodating housing environment at affordable prices for persons experiencing diminishing capabilities and changing needs. Such a policy would undergird the desire to remain in one's own home or in independent senior housing facilities by providing the financing and development of appropriate home and community-based service arrangements.

6. Providers of Care

The salaried providers of care must be appropriately trained and adequately compensated in salary and benefits. Informal caregivers should also be provided with training, counseling, respite, recognition, and, where appropriate, financial incentives.

7. Personal Autonomy

Persons who require care in their own home or in community settings, or those who are residents of institutions, have a right to determine care decisions either directly or through caregivers and guardians, including the right to refuse or terminate services. The exercise of that right requires choice from among an appropriate range of health and social services.

8. Rehabilitation

   A comprehensive long-term care program should include rehabilitation services to restore and maintain optimal physical and mental functioning.

9. Multigenerational Needs

   Impairments affect persons of all ages. The personal and public burdens of care are largely cross-generational. Long-term care public policy must be designed to incorporate these multi-generational factors.

10. Cultural Diversity

    An effective long-term care system must respect cultural and group differences among beneficiaries as well as among providers of care.

11. Research

    A comprehensive long-term care system includes adequate outlays of public and private research resources into the causes and treatment of chronic impairment. The

> findings of past and existing research must be more efficiently incorporated into current community and institutional practice with special care to assist informal caregivers to utilize new information. Such research must include efforts to define and advance quality standards for long-term care.

We urge Congress to make adult day care a Medicare benefit available to functionally impaired adults. The need is there, the time is right. NCOA/NIAD is interested in working with you on the Commission and in the Congress in this legislative and implementation process.

DH/eb
testimon

Saint Alexis Hospital Medical Center

5163 BROADWAY • CLEVELAND, OHIO 44127-1593 • (216) 641-3300

June 29, 1989

Jan Papez
District Office of Congresswoman Oakar
523 Federal Court Building
215 Superior Avenue
Cleveland, Ohio 44114-1281

Dear Ms. Papez,

Enclosed please find written testimony to be submitted for the official record for the hearing concerning health issues scheduled for Thursday, July 6, 1989 at 9:30 a.m.

Either I or a designated member of my staff will be attending the hearing.

Thank you for your attention to our views on these important issues.

Sincerely,

Larry K. Lehner
President and CEO

LKL/ms

Enc.

Testimony of Larry K. Lehner, President and CEO
Saint Alexis Hospital Medical Center

June 29, 1989

Proverb

> He who has health has hope.
> He who has hope has everything.
> Anonymous

Introduction

Saint Alexis Hospital Medical Center has served the Broadway-East 55th area at the same location since its establishment in 1884. The Medical Center currently operates a 181-bed community hospital with 35 skilled nursing beds. Expenses for 1987 were slightly over $ 31 million. In 1987, Saint Alexis had 6,443 patient admissions, 56,789 days of care and a 7.1 day average length of stay. The Medical Center employs over 700 people and has a medical staff of over 100 physicians.

Saint Alexis Hospital Medical Center was founded during the period of industrial development in the Midwest. The neighborhood was home to the recent immigrants from Eastern Europe who provided the labor in the steel industry. Over the years, basic heavy industry has been part of the neighborhood's life. The urban exodus of the 50's and 60's coupled with the recent economic downturn has greatly affected the Broadway neighborhood. The area remains a blue collar area, but cutbacks in the heavy industries have had a disproportionate effect.

Problem Statement

For the most part, those who come to Saint Alexis for medical care are those who live in the neighborhood where the hospital is located.

The neighborhood contains a population with the characteristics shown in Table 1.

Table 1 - Selected Population Characteristics of U.S. and Postal Zip Codes 44145 and 44127, 1980 Census

	U.S.	44105	44127
Population 1980	226.5 m.	62,956	9,714
% below Poverty Level	13	15.6	16.2
Unemployment (15+ years)	(%)	(%)	(%)
Unemployment 1-4 weeks	43.1	27.1	29.0
Unemployment 5-14 weeks	32.4	32.2	34.7
Unemployment 15 + weeks	24.5	41.3	36.3
	N=7.6 m	N=6673	N=1010
Median Age	30.0	28.8	31.5
Race:	(%)	(%)	(%)
White	85.9	45.9	95.8
Black	11.8	53.2	0.7
Other	2.3	0.8	3.4
Marital Status (14+ years)			
	(%)	(%)	(%)
Married	65.5	46.2	50.0
Unmarried	34.5	53.8	50.0

Source: CACI, "Demographic and Income Forecast Report", Arlington, Virginia, 1986.

The local population has a higher poverty rate than the national, and it is more subject to long-term unemployment. Both areas have a substantially less married population than does the country as a whole. One area is predominantly older and white, and projected to remain that way. The other is racially mixed and projected to become more black. Both areas are losing populations.

Walking around in the area tends to reinforce the impression conveyed by the statistics. There is an air of depression about the place. Situated next to the industrial flats of Cleveland, where far more people have been laid off than hired in recent years, this is stereotypical "rust belt" country. There isn't much wealth here. There isn't much political clout here. But there is poverty, discouragement, and pain aplenty. It is the people here who are served by Saint Alexis.

The people who come to Saint Alexis, and who cannot pay for their treatment there, reflect the place from which they come. Their profile is shown in the numbers of Table 2.

Table 2 - Characteristics of Indigent Care Receivers

AGE	NATIONAL (%)	SAINT ALEXIS (%)
0 - 17	33.0	50.1
18 - 24	23.6	11.2
25 - 34	17.7	14.3
35 - 44	9.7	6.0
45 - 54	7.7	7.0
55 - 64	8.3	5.6
65 +	NA	5.8
RACE		
White	79.3	65.4
Black	17.3	31.0
Other	3.5	3.6
SEX		
Male	51.1	53.4
Female	48.9	46.6
TYPE OF ADMISSION		
Emergency	--	64.4
Inpatient	--	10.2
Outpatient	--	25.4
MARITAL STATUS		
Married	--	37.7
Unmarried	--	62.3
EMPLOYMENT STATUS (under 65)		
Employed (full or part-time)	6.5	51.0
Unemployed	3.5	49.0

Source: Sulvetta, Margaret and Swartz, Katherine, The Uninsured and Uncompensated Care: A Chartbook, Washington, D.C., 1986, and the Medical Records of Saint Alexis Hospital Medical Center, October 8, 1987.

A local picture, involving hundreds of people and thousands of dollars lends itself to statistical treatment. It is difficult to quantify pain, sorrow, and misery. Those things are personal, they are individual, they are almost ethereal to the observer. Yet, they are part of the reality that the lack of access to medical care entails.

The indigent care provided by Saint Alexis generally follows the pattern of the United States as a whole. As Table 3 shows, there has been a steady increase in the dollar value of care over the 1980-1985 period.

Table 3 - Indigent Care 1980 - 1985 (In Millions $)

	1980	1981	1982	1983	1984	1985	% Increase 1980 - 1985
Saint Alexis	1.77	1.58	2.21	2.78	2.64	2.96	67.2
Greater Cleveland	53.88	62.28	72.19	83.46	94.88	86.84	61.2
U.S. (Billions)	4.6	5.6	6.5	7.8	9.5	9.5	106.5

Table 4 - Indigent Care 1980 - 1985 (As Percent of Gross Revenue)

	1980	1981	1982	1983	1984	1985	1980 - 1985
Saint Alexis	5.94	4.87	5.22	5.32	5.64	6.73	13.3
Greater Cleveland	4.98	4.73	4.39	4.40	5.03	4.91	0
U.S. (Billions)	3.6	NA	NA	NA	4.6	5.7	58.3

Sources: The Center for Health Affairs, Greater Cleveland Hospital Association, 1987.

As Table 4 shows, the percentage increase in dollars over the period has been substantially less than that for the U.S., but slightly greater than the average increase for other hospitals in the Greater Cleveland area. The dollars nationally show some indication of leveling off toward the end of the period, but this does not appear to be the case at Saint Alexis or in Cleveland.

Looking a bit more closely at the local situation in Table 5, we do see data which tend to reinforce that in Table 4.

Table 5 - Indigent Care (As Percent of Gross Revenue)
1984, in Greater Cleveland Hospitals

By Hospital Size (beds)	
500+	6.6
400 - 499	3.9
300 - 399	3.3
200 - 299	3.3
Less than 200	3.3
All	4.7
By Teaching Status	
Teaching Hosp.	5.7
Advanced	6.4
Other	4.4
Non-Teaching	2.5
All	4.7
Saint Alexis	5.31

Source: The Center for Health Affairs, Greater Cleveland Hospital Association, 1985.

Saint Alexis carried a significantly higher amount of indigent care than is the case for most hospitals in the region. It does more indigent care than is the case of other hospitals of its size, and more than twice as much as other non-teaching institutions. This is probably partly because of Saint Alexis historical orientation toward charity, and partly because of the situation of the clientele it serves. In the case of the former, other hospitals may or may not share a predisposition to serve the poor. In the case of the latter, Saint Alexis has a lot of the poor to serve.

While there are no major surprises here, there are a couple of observations worth making. By far the largest single segment of the uninsured population by age is children. Given the cost of hospital care, it seems unlikely that these indigents are likely to take care of themselves. If their parents are unable or unwilling to do so, it does appear that the "just and humane" society has an obligation to step in. Second, the finding that the majority of the uninsured are employed tends to reinforce the reluctance of employers to provide insurance coverage.

Our Mission at Saint Alexis

If, indeed, our community is to be confronted with increasing numbers of medically indigent persons, the use of the term "uncompensated care" to describe the problem is in some respects misleading. This care has never been, is not now, and never will be uncompensated. The real question is who is paying for the care not paid for by the receivers of it?

Historically, of course, the manifest payers for the care have been the care providers themselves, particularly provider organizations like hospitals. By equating indigent care with uncompensated care, and defining uncompensated care as provider charity plus bad debt, the hospitals have been indeed the payers.

It is clear that Saint Alexis is doing and has been doing a substantial amount of care for the poor for a very long time.

If an individual needs medical care but cannot afford a private physician, the Ambulatory Health Care Center at Saint Alexis Hospital can help. Established in 1923, the Ambulatory Health Care Center provides outpatient medical care to area residents. Staff members also give information to and teach their patients, promoting good health in the community.

The staff provides diagnostic measures and treatment of many medical conditions, including cancer, diabetes, hypertension, pregnancy and colds. Also, a patient might visit the Center with a dermatology problem, an upper respiratory infection, heart problems, arthritis or in the event of a minor accident. The Center also offers complete maternity care and free blood pressure and diabetes screenings.

Through the services provided by the Ambulatory Health Care Center, we place our emphasis on good health and the prevention of disease. The Medical Center also provides inpatient and emergency care as necessary, regardless of an individual's ability to pay.

Innercity community hospitals provide the hope of health to the city's residents. The increasing burden of providing these services deprives the community hospital of its health and well-being. In order to survive and continue to provide these vital health care services to the residents of our community, funding sources must be found that small businesses can afford. Maintaining a business's ability to employ and insure it's employees keeps individuals off the indigent rolls. It is beneficial to both parties.

Thank you for the opportunity to discuss this issue from the point of view of Saint Alexis Hospital Medical Center.

June 29, 1989

Testimony directed to the U.S. Bi-partisan Commission on Comprehensive Health Care, at it's hearing held in Cleveland, under the auspices of Commission member Mary Rose Oakar, on Thursday, July 6, 1989.

The fact that this commission exists, and hearings such as this are being held across our country, amply demonstrates that the need for thorough up-grading of our health delivery system is widely recognized. This, in order to make Quality health care available to all our people, as a right. It is no longer a question of "If and Why", but rather "When and How".

The statistics of the millions of our citizens with no health insurance, and the additional millions with inadequate coverage, are widely known. As is the percentage of our G.N.P., spent on our health care as compared to say, our neighbor Canada, which has a National Health plan. And, the 600 billion dollars per year, being spent at present, representing both private and government expenditures. A lot of money for a health care system, which quality wise is one of the best, yet leaves huge gaps in it's availabilty and affordability. Surely, we can do better.

This is a system that calls for fundamental changes, not band-aid approaches, that avoid treating the root cause of the problem, and are expensive in themselves.

Our country is the only industrialized nation in the world, with the exception of South Africa, that does not have a form of Comprehensive Health Care. It is time that we fall in line. Our northern neighbor, Canada, has a system that is working well. We could do worse than use their plan for a guideline for ourselves, adapting it to our needs and conditions.

Here, in Ohio, there is a piece of legislation, H.B. 425-Universal Health Care in Ohio, that has been introduced and in committee, that could very well be used for a federal plan.

An important feature of a functioning health care system, would be in it's emphasis on preventitive health care, which would serve to reduce the extent of hospitalization, which is much more expensive, and after the fact.

A pressing health care problem, affecting mainly the elderly, is the need ~~the need~~ and cost of skilled and unskilled nursing and custodial care. Provision for home care as an alternative to institutional care, should be included, where possible, as more beneficial to the patient and families involved, and generally less expensive than nursing homes.

(continued on page 2)

Financing of a comprehensive Health Care Plan, can be accomplished in the main, through converting the present 600 billion dollar annual expenditures, with a combination of taxes, and/or premiums, utilizing, eventually Medicare funds and other government funding for health care. Elimination of excessive paper work, uneeded administrative costs, and the curtailing os much private insurance profits, would add billions to direct funding.

Finally, any comprehensive plan should provide coverage to all sections of our population, young and old, and must be accompanied by a workable cost containment system, that would keep rapidly escalating health costs in line, and give us a bigger bang for the buck.

Respectfully submitted by,
Morris Hybloom
1227 Drury Ct. #408
Mayfield Hts. Ohio 44124
(216) 449-7514

216-331-7921

ROBERT R. CAVANO
1087 WHITTLESAY LANE
ROCKY RIVER, OHIO 44116

My name is Robert R. Cavano and I live in Rocky River, Ohio, a western surburb of Cleveland, Ohio.

I currently serve as a member of the Board of Trustees of MetroHealth, the public hospital for Cuyahoga County. There is no pay for this position.

Until June 1 of this year I was the President of The L. A. Lux Company, a small chemical manufacturing company in Cleveland. We have long provided a high level of Blue Cross/Blue Shield coverage for our employees.

Needless to say, I do not speak today as a representative of either of these organizations, but my personal opinions were partially formed from my association with them.

Our company health care coverage is part of a C.O.S.E. contract and we commend that organization for obtaining favorable rates for small businesses through group purchases. We do, however, disagree strongly with several C.O.S.E. policies and I suspect that we are not alone.

We disagree with them on their opposition to a national health program. I have never been personally convinced that American cannot afford such a policy.

Canada spends considerably less than we do on health care and has lower infant mortality. They also have a greater life expectancy, but some say that is because they must stay alive longer to take advantage of their back-up in health service delivery.

We don't want to repeat errors that have been made in Canada and England, and we need not, but isn't it time we began to consider some of the favorable results of their programs?

We also disagree with C.O.S.E. on the matter of requirements or incentives for employers to carry health coverage for its employees. Many businesses already pay these costs and then through their corporate and personal taxes pay again for those not covered.

I prefer universal coverage under a national plan as a solution, but until that comes I think that comprehensive health care insurance should be a part of every employment contract.

SINCE 1923

GREATER ◦ DAYTON ◦ AREA
HOSPITAL ASSOCIATION
32 North Main Street • Suite 1201 • Dayton, Ohio 45402-1942 • (513) 228-1000

July 6, 1989

JUL 10 1989

Representative Mary Rose Oakar
House Office Building
Washington, D.C. 20510

Dear Repensentative Oakar:

Yesterday, I had the opportunity to testify yesterday before three members of the U.S. Bipartisan Commission on Comprehensive Health Care in Cincinnati, Ohio, and I wanted to provide you with a synopsis of my recommendations as they apply to long term care. I have also enclosed a copy of my testimony (a separate folder was given to the Commission staff in Cincinnati yesterday for your benefit). I will follow up with your office later to see if you have any questions.

My recommendations included:

1. **asking Congress to recommend that a demonstration project(s) be approved by the Department of Health and Human Services to evaluate the cost-benefit of urban swingbeds. Authorizing legislation for this demonstration was in the 1980 Omnibus Budget Reconciliation Act but has never been implemented.**
2. **authorizing as part of this demonstration project the development of a clinical and financial data base on subacute care services in a hospital swingbed setting.**
3. **evaluation of revising the Medicare extended or skilled nursing care benefit to a subacute care benefit to reflect changes in patient acuity and needs following hospitalization and to evaluate the cost-effectiveness of substituting subacute care services for patients on the margin for hospitalization.**

Representative Oakar, as you well know, one of the main reasons that the elderly enter a long term care facility is due to inadequate alternative care services following a hospital admission. Many hospitalized elderly are being discharged to a nursing home for what should be a two or three week stay, and what ends up to be for the rest of their life. A subacute care swingbed program, modeled on the successful rural swingbed program, would allow the Medicare patient to stay until he or she was able to return home to an independent life, would minimize or eliminate an unnecessary long term care placement, would optimize patient outcomes following a hospital stay, and could reduce overall Medicare and Medicaid expenditures through decreased readmission rates to hospitals or substitution of sites effect.

GDAHA has been working very hard to get such a demonstration up and running but we need Congressional support and action to get HCFA interested in a subacute care program.

The changes being considered in the catastrophic legislation should allow you and your colleagues to take action yet this year to get a demonstration up and running. I would ask for your support of this request.

Thank you very much for this opportunity to address a solution to part of the long term care dilemma for the elderly.

Sincerely yours,

Sarah A Grim

Sarah A. Grim
President

SAG/sgt

Attachment

TESTIMONY OF THE
GREATER DAYTON AREA HOSPITAL ASSOCIATION

BEFORE THE
UNITED STATES BIPARTISAN COMMISSION
ON COMPREHENSIVE HEALTH CARE

JULY 5, 1989

CINCINNATI, OHIO

Good morning. My name is Sarah A. Grim and I am President of the Greater Dayton Area Hospital Association (GDAHA), a hospital trade association representing eighteen hospitals in Clark, Darke, Miami, Montgomery, Shelby, and Greene counties. I appreciate the opportunity to provide testimony before this Commission, which was created to examine shortcomings in the current health care delivery and financing systems that limit or prevent access to comprehensive health care for all residents of the United States. The Association supports the work of the Commission as it studies the complex problems associated with both the working uninsured and those persons needing long term care services.

I have been involved in long term care policy and program development in both an academic university medical center and a private community hospital as well as in state and metropolitan hospital associations since 1979. My testimony today will focus upon subacute care as one component of the long term care continuum. My intent is to provide members of the Commission with information about one program that can address part of the problem of access to long term care services -- and perhaps provide a cost-effective means of doing so. I will briefly describe this program, address the benefits that such a program brings to the Medicare and Medicaid Programs, address patient outcomes, and finally propose -- for the Commission's consideration -- a model program that can be initiated this year with Congressional support.

NATURE OF THE PROBLEM

The advent of the Medicare prospective payment system (PPS) has created a new category of patient that remains in the nation's hospitals at a cost to the provider, to federal and state governments, and to the patient himself. This new patient is the subacute care patient. The subacute care patient is a patient with extraordinarily high acuity levels, who requires less care than in the acute care setting but more than that typically provided in a long term care facility.

Subacute care has been defined by the Prospective Payment Assessment Commission (ProPAC) as "care provided to patients who do not meet established criteria for "medically necessary acute care"." [1] Subacute care includes that which "is immediate postacute care, that is intensive in terms of the needs of the patient and the skill and the time of the provider. This is sometimes called "super-skilled" nursing care or subacute care. At the other end of the subacute care spectrum is care which is custodial in nature." [2]

According to the American Hospital Association, hospitals across the country provide over 500,000 to 700,000 days of care to subacute care patients. In 1988, ProPAC found that fifty-five percent of all subacute care patients in hospitals were awaiting nursing home placement. These same patients also accounted for eighty percent of all subacute days of care (see Exhibit A). On an average day in GDAHA member hospitals, there are over 70 patients awaiting placement in nursing homes (see Exhibit B).

Because subacute care is not an accepted level of care or benefit for payment purposes, reimbursement for subacute care patients is limited. Neither Medicare nor Medicaid define subacute care as an eligible program service.

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[1] Prospective Payment Assessment Commission, Medicare Prospective Payment and the American Health Care System, Report to Congress (Chicago: Commerce Clearing House, Inc. [July 26, 1989]), p. 15.

[2] Prospective Payment Assessment Commission, Report and Recommendations to the Secretary of Health and Human Services (Chicago: Commerce Clearing House, Inc. [March 24, 1988]), p. 115.

The lack of recognition by both Medicare and Medicaid of the subacute care patient creates a particular problem for providers and patients. Currently, the subacute care patient stays in the hospital setting -- awaiting placement in a nursing home from one day to over one year or more -- depending on the patient's care requirements, the availability of certified nursing home beds, the level and expertise of nursing home staffs, and a family's ability to pay for the patient in a long term care setting. Nursing homes are typically loath to accept these patients due to problems with reimbursement, staffing, and care requirements.

For the hospital provider, the subacute care patient presents a problem in both the financing and the delivery of subacute care services. For the patient and the family, a major problem is trying to find alternative sites for placement. Nursing home placements are generally the least acceptable for both patients and families for obvious reasons. According to most estimates, between 25% to 40% of institutionalized persons are placed in nursing homes due to a lack of alternative care services.[3] Over sixty-two percent of institutionalized persons are admitted directly from a hospital setting. The average length of stay in a nursing home is two years -- and once entered, a patient usually dies there.[4]

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[3] C. Carl Pegels, Health Care and the Elderly (Rockville: Aspen [1980]), p. 40.

[4] Ibid., p. 83.

THE SWINGBED PROGRAM

In 1980, Congress passed the Omnibus Budget Reconciliation Act, which included a provision that created hospital swingbeds in rural hospitals. The swingbed provision allowed rural hospitals, with less than 50 beds, to provide three levels of care -- acute care, skilled care, and intermediate care -- where only acute care was provided before. The swingbed program was intended to augment long term care services or provide a substitute site for long term care in rural areas with long term care bed shortages. In 1987, Congress expanded the rural swingbed program to hospitals with up to 99 beds.

The swingbed program offered a variety of benefits to patients and families by improving patient outcomes, increasing access to postacute care services in their own community, decreasing patient transfers to nursing homes for patients not requiring long term care placement, and reducing readmissions to hospitals.

In May 1989, the Health Care Financing Administration released its study of the rural swingbed program.[5] The study findings are especially relevant to today's hearings:

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[5] Center for Health Services Research, Hospital Swing Beds: A Study of Long Term Care Provided in Acute Care Beds in Rural America 1982 - 1986 (Denver: University of Colorado Health Sciences Center [May 1989]), p. vi - viii.

- over 90% of swingbed hospitals use swingbeds to provide care to relatively short-stay subacute, long term care patients that are more difficult to place in community nursing homes due to their intense needs for medical and skilled nursing care. Because of this, swingbeds are more successful in retaining patients in their home communities.

- swingbed patients have typically shorter stays and have greater rehabilitation potential than typical nursing home residents. Swingbed patients are typically 20 percent more costly to care for than nursing home residents.

- swingbed patients tend to improve and stabilize more rapidly than nursing home patients. Swingbed patients are discharged home more frequently than nursing home residents who frequently fall subject to "dependency fostering".

- swingbed patients are hospitalized less frequently within the first six months after admission, and hospitalized less frequently during the six months following discharge.

- swingbed patients are rehabilitated more quickly due to more frequent physician visits and the general therapeutic orientation of hospitals, which translates into earlier discharge home and reduced hospitalization rates.

- swingbed patients have an average length of stay of 19 days while nursing home residents have an average length of stay of 491 days. Forty-five percent of all swingbed patients are discharged home (versus 35% for nursing homes). Three percent of all swingbed patients were readmitted to acute care versus twenty-seven percent for nursing home patients.

- swingbed hospitals were better than nursing homes on: improving urinary and bowel incontinence, mobility impairment, cognitive, bathing, feeding and grooming abilities, ability to transfer, and stabilization of tissue fluid swelling (see Exhibit C).

The HCFA report recommended that demonstration projects modeled along the lines of the swingbed program should be done on a more widespread basis, stating that "the swingbed program has "settled in" nationally to fill community gaps, especially in the areas of subacute care and "short-term long term care"."[6]

THE NEED FOR SUBACUTE CARE MODELING

In its March 24, 1988, Report to the Secretary of HHS, ProPAC stated that there is a need to further study variations in access to postacute care for Medicare beneficiaries as well as continued interest in the impact of the prospective payment system upon quality of care.[7] In February, 1989, HCFA issued a request for proposals (RFP) that focused upon access to quality care under Medicare and Medicaid, refinement of current long term care delivery and payment systems under Medicare or Medicaid, and studies addressing the changes inherent in the Catastrophic Coverage Act. Of particular significance in this RFP was a stated interest on the part of HCFA to see new and innovative approaches to the delivery and payment for subacute care.[8]

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[6] Ibid., p. 12.

The Greater Dayton Area Hospital Association greatly supports the suggestions from both ProPAC and HCFA that studies need to be done on subacute care. We have devoted considerable time to modeling a program that would accomplish several objectives of interest to HCFA, ProPAC, and ultimately to Congress, by:

- identifying subacute care as a definable patient classification system with defined parameters and criteria.

- developing a data base from which to assess the cost and quality of subacute care services.

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[7] Prospective Payment Assessment Commission, Report and Recommendations to the Secretary of Health and Human Services (Chicago: Commerce Clearing House, Inc. [March 24, 1989]), p. 116.

[8] HCFA, "Health Care Financing and Demonstrations, Availability of Funds for Cooperative Agreements", Federal Register 20, 1 February 1989, 5147.

- developing a reimbursement and benefit program for subacute care services.
- evaluating the cost-effectiveness of subacute care services upon hospital admission and readmission rates, and permanent placement in long term care facilities.

The model program that we have developed would allow hospitals to implement the swingbed program for the provision of subacute care services to qualified Medicare or Medicaid patients. The 1980 swingbed enabling legislation provided for such urban swingbed programs upon approval by the Secretary of the Department of Health and Human Services but there has been no such action taken by DHHS since the 1980 legislation passed. GDAHA believes that an urban swingbed model program for subacute care services could be implemented quickly and relatively inexpensively -- with demonstrable results for federal and state governments, for providers, and for patients and their families (see Exhibit D).

The subacute care demonstration model needs your support to go forward. Until there is a data base established to define subacute care and establish costs associated with its provision, subacute care cannot meet its full potential within the long term care spectrum. There is a recognition that subacute care exists -- now we need an opportunity to do something about it.

GDAHA believes that subacute care programs will provide an answer to part of the problem of long term care -- by providing quality care at a reasonable cost and by deferring or eliminating an unnecessary long term care placement until absolutely necessary.

We ask your consideration of our proposal today and in the future as you proceed with your tasks.

Thank you very much for this opportunity to address you today.

Sincerely yours,

Sarah A. Grim
President

SAG/sgt

Attachments

EXHIBIT A

MEDICARE and MEDICAID

NUMBER 550 MARCH 24, 1988

—EXTRA EDITION—

L

Prospective Payment Assessment Commission

Report and Recommendations to Secretary of HHS

Including

Technical Appendixes

Extra copies of this Extra Edition are available from Commerce Clearing House, Inc., 4025 W. Peterson Ave., Chicago, Illinois 60646. Price: 1-4 copies, $5.00 each; 5-9 copies, $4.75 each; 10-24 copies, $4.50 each; 25-49 copies, $4.00 each.

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significant in rural areas, and recent closings of small, rural hospitals compound the problem.

The study found that hospitals have responded creatively to the needs of borderline cases. Examples include residence halls or hotels near hospitals and increasing use of 23-hour observation units.

Conclusions

In general, the study indicates that PRO preadmission review does not result in quality of care or access problems. This is largely because the limited scope and the decision sequence of the review process results in minimal payment denials.

The 23-hour observation units seem to be an important quality-of-care mechanism for patient safety, as well as hospital financial protection.

Hospitals' informal review activities have supplanted some formal PRO review.

The variation in explicit preadmission review criteria across PROs may lead to inconsistent decisions. The limitations on the use of social criteria is another concern, particularly for patients in rural areas.

Some confusion remains about the PRO preadmission review goals and process. Although physicians are becoming more familiar with the program, further education for physicians, hospitals, and beneficiaries is desirable. To improve beneficiaries' protection and satisfaction, there should be more education about PRO and other types of preadmission review.

SUBACUTE AND TRANSITIONAL CARE

The Commission's major extramural study of subacute and transitional care in hospitals will be completed in the spring. This summary provides a brief background of the study and a discussion of some preliminary findings. In subsequent Commission Technical Reports and in ProPAC's June 1988 report to the Congress, *Medicare Prospective Payment And The American Health Care System*, additional information will be presented.

Background

In previous reports, ProPAC noted its concern about the impact of PPS on beneficiaries' needs for post-acute care services. This led to a major research project on subacute and transitional care. Contracts were awarded to Lewin and Associates (Lewin) and the American Hospital Association (AHA) for the study, which is designed to:

- Describe what is meant by subacute and transitional care.
- Measure and describe the prevalence and distribution of subacute and transitional care.
- Determine cost and payment sources for this care, and,
- Describe the implications of these findings on quality of care.

The study addresses these issues primarily through a national survey of hospitals, conducted by AHA and analyzed by Lewin, and case studies by Lewin in five states.

Preliminary Findings

Preliminary findings described below are based on initial review and analysis of national survey data, and completion of the five case studies. Extensive analysis and review is continuing. ProPAC anticipates that this additional work will result in the development of a much more definitive list of issues and findings.

Definition of Subacute or Transitional Care—Subacute care offered by hospitals may be defined—and most often is defined— as care provided to patients who do not meet established criteria for "medically necessary acute care." There is a wide range of service intensity associated with subacute care. At one end of the spectrum is immediate post-acute care that is intensive in terms of the needs of the patient and the skill and time of the provider. This care is sometimes called "super-skilled" nursing or subacute care. At the other end of the subacute care spectrum is care which is custodial in nature, involving minimal needs of the patient and minimum provider time and skill.

Incidence—The frequency of subacute care in acute care beds is small. The national survey indicates that about five percent of discharged Medicare patients spend at least one day as an identified subacute patient, resulting in just over 4 becoming more localized and less national. The Medicare program is designed as a national program with national benefits. Changes in this program orientation deserve the careful attention of policy-makers.

million days of Medicare subacute care in acute care beds per year. About half of the patients classified as subacute spend one week or less in this status.

Types of Subacute Care—Subacute patients in acute care beds can be generally classified into several categories that are not necessarily mutually exclusive:

- Patients assigned to observation beds, usually associated with temporary care situations such as outpatient post-surgical care.
- Patients receiving hotel-type services.
- Patients who pay for their own care at a subacute level.
- Patients in swing beds.
- Patients awaiting placement in a nursing home, and.
- Patients in hospital-attached or hospital-based nursing homes.

Fifty-five percent of subacute patients are awaiting nursing home placement. These patients also account for the vast majority—80 percent—of the subacute days of care. The extent of subacute care that results from patients awaiting placement varies from place to place. Some states seem to experience enormous numbers of subacute days in part because of the nursing home placement back-up, while others with similar proportions of nursing home beds report many fewer days of subacute care in acute care beds.

Similar patients can be found in nursing homes and at home—with or without home care.

Cost and Payment for Subacute Care—It appears that substantial portions of currently-defined subacute days were previously included in the inpatient stay. This is particularly evident in cases where the patient is moved after a very short acute-hospital stay into an attached nursing home, PPS-exempt unit, or home care in order to recover or receive rehabilitation services. In some of these situations Medicare may be paying "twice." In other situations, the beneficiary may have to pay for post-acute nursing home or home care during a recovery period that was previously considered part of the Medicare-covered acute care stay. This is troublesome in light of the fact that Medicare-reimbursed days of skilled nursing facility (SNF) care and home health visits per enrollee have declined since 1984.

The cost and payment impacts related to subacute care are extremely dependent upon state, local, and regional policies and conditions. Factors related to the variations include: state regulatory control over nursing home bed additions or hospital bed conversions; fiscal intermediary practices; and use and application of medical necessity criteria by PROs, fiscal intermediaries, or hospitals themselves.

Quality of Care—The impact of subacute care on quality of patient care is likewise dependent to a great extent on particular circumstances, practices, and alternatives available to local hospitals. Generally, a number of the practices encountered and reported appear to enhance quality of care. For example, while the national average length of stay for Medicare orthopedic joint replacement patients is about 15 days, case study hospitals with attached nursing home beds have reduced the acute portion of the stay to three to six days. Patients are then moved to the attached nursing home, but preliminary observations indicate that intense and skillful treatment patterns exist in many of these situations.

Primary Issues for Further Review

Several issues seem critical at this point, although there is need for additional review and refinement of the data. Most important among these issues is variation in beneficiary access to post-acute care. That is, there may be increasingly differential access to Medicare-covered post-acute care.

The meaning of "medically-necessary acute care" is being redefined nationally as a result of PPS payment and incentives. At the same time, implementation of Medicare coverage policy often occurs at the local level. These decisions interact with other local conditions to change the nature of Medicare coverage for a spell of illness. Consideration needs to be given to whether the value of Medicare coverage of an acute spell of illness is

EXHIBIT B

EXAMPLES OF HARD TO PLACE PATIENTS
IN GDAHA HOSPITALS
1989

In early 1989, GDAHA asked member hospitals to provide staff with examples of types of patients that were especially difficult to place in area nursing homes. These patients would have been ideal subacute care swingbed patients if such a program had been available in the greater Dayton area.

EXAMPLE: Patient was ready for discharge in July, 1988, but was unable to be placed until January, 1989. Medicare reimbursement paid $50,000; hospital's costs were $97,629.

EXAMPLE: Patients both admitted in June and July of 1988, unable to find placement as of March, 1989. Both are ventilator-dependent, with little or no rehabilitation potential. Medicare reimbursement is expected to fall $200,000 short of the costs associated with both patients.

EXAMPLE: Patient admitted in January, 1988, for respiratory distress, intubated, and put on a ventilator. Patient was placed in a nursing home 40 miles from home in May, 1988. Nursing home placements were tried as far away as Indian Lake and Canterbury, Ohio. Typical waiting lists in GDAHA service area range from six months to a year for patients with trachs or those who are ventilator dependent. Cost of care for this one patient: $182,309.

EXAMPLE: Patient admitted in May, 1988, and discharged in November, 1988. Patient had abdominal surgery and required hyperalimentation. Patient was also on continuous IV drip for heart irregularity. Nursing homes refused to take him but was placed finally in a hospital's rehabilitation unit. Cost of care at discharge: $136,069.

EXAMPLE: Patient admitted December, 1988, and discharged on February 5, 1989. Patient was suspected I.M. drug user required IV antibiotics. Only two nursing homes in county would take "highly skilled" patients. Patient stayed in hospital until she was off IV antibiotics and able to be discharged home. Cost of care: $22,000.

EXAMPLE: Patient admitted in September, 1988, with head trauma. Patient's course of treatment included a trach and tube feeding. Nursing homes refused to take patients with highly skilled care requirements. Patient discharged on December 12, 1988. Cost of care: $29,593.

EXAMPLE: Patient admitted from local MR/DD facility with NG-tube on August, 1988. Patient's level of care elevated so MR/DD facility could not take the patient back upon discharge. Patient was finally discharged back on November 15, 1988. Cost of care: $59,126.

EXAMPLE: Area nursing homes have limited skilled care capabilities. Patients requiring high intensity of nursing services who do not have separate private ability to pay are generally last to be allotted to an extended care bed. Costs one hospital $580 per day to provide postacute care and many patients stay over 100 days.

EXHIBIT C

TABLE IV.1: General Characteristics of Long-Term Care Patients in Swing-Bed Hospitals and Nursing Homes, 1984 and 1985.[a]

Characteristics	Mean for Swing-Bed Hospital Patients[b]	Mean for Nursing Home Patients[b]
Age (Years)	81.2	81.4*
Distance to Residence (Miles)	20.8	49.9**
Married (%)	29.4	17.3
Skilled Nursing Care Classification (%)	60.1	37.3
Admitted from Acute Care (%)	75.9	50.8
Good to Moderate Rehabilitation Potential (%)	54.3	21.1
Current Stay Less Than 30 Days (%)	55.6	8.1
Medicare Primary Payer (%)	46.4	8.7

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[a] Based on a sample of 552 patients in 33 swing-bed hospitals and 540 patients in 40 nursing homes.

[b] Mean differences are significant at $p<.001$ unless asterisked: a double asterisk (**) implies significance between the .001 and .05 levels, while a single asterisk (*) implies significance between the .05 and .10 levels.

TABLE V.3: Discharge Status Profiles for Swing-Bed Patients and Nursing Home Patients.[a]

Discharge Status Characteristics	Swing-Bed Mean[b]	Nursing Home Mean[b]
All Discharges		
Length of Stay (In Days) Until Discharge[c]	19.8	491.4
Mortality Rate (%)	17.8	58.5
For Live Discharges Only		
Utilization Attributes		
Discharged with Written Discharge Plan (%)	97.4	76.5
Discharged Home (%)	45.9	35.5
Discharged to Acute Care (%)	3.1	27.7
Discharged to Nursing Home (%)	47.5	30.1
If Discharged Home, Discharged with Home Health Care (%)	33.3	25.6^{n}
Patient Status Indicators		
Urinary Tract Infection: Urinalysis/Culture Proven (%)	16.9	3.0
Ulceration of Skin (%)	12.8	4.6
Dependent in Bathing Scale (0-5)[d]	3.1	2.9*
Mobility Impairment Scale (0-3)[d]	0.7	0.4
Pronunciation Problems Scale (0-3)[d]	0.4	0.3^{n}
Psychotic Symptoms Scale (0-2)[d]	0.0	0.1
For Discharges Due to Death		
Primary Cause of Death:		
Neoplasm (%)	33.3	16.8*
Circulatory Disorder (%)	27.8	45.2*
Respiratory Disorder (%)	2.8	18.4

---

[a] Based on a random sample of discharges including 242 swing-bed patients in 17 swing-bed hospitals and 410 nursing home patients in 24 nursing homes.

[b] Mean differences are significant at $p<.05$ unless the nursing home value is superscripted with an asterisk or a lowercase n. A single asterisk (*) implies significance with $.05 \leq p < .10$. A double asterisk (**) implies significance with $.10 \leq p \leq .20$. A superscript n implies insignificance with $p > .20$.

[c] Length of stay data were obtained for larger samples of patients than those indicated in footnote a.

[d] Numbers in parentheses denote the range of values taken on by an ordinal scale, with larger values denoting greater dependency.

TABLE VI.6: **Outcome Patterns of Patient Status Improvement and Stabilization for Swing-Bed Hospital Patients Relative to Nursing Home Patients for Selected Patient Status Indicators, Adjusted for Case Mix Using Logistic Regression for Three Longitudinal Samples.**[a]

Outcome Pattern Indicator	Swing-Bed Hospital Mean: % Patients	Nursing Home Mean: % Patients	Unadjusted Mean Diff.	Unadj. Signif.[b]	Case Mix-Adjusted Mean Diff.[c]	Case Mix-Adjusted Signif.[c]
In-Facility Stratified Sample						
Improvement in:						
Urinary Incontinence	40.4	18.7	21.7	.009	26.4	.002
Mobility Impairment	33.0	15.3	17.7	.002	17.1	.006
Bowel Incontinence	30.7	14.0	16.7	.010	19.5	.010
Bathing Ability	26.3	13.3	13.0	.002	11.4	.022
Katz Score	32.9	19.4	13.5	.005	11.1	.055
Feeding Ability	29.5	18.0	11.5	.044	10.5	.094
Ability to Transfer	28.0	19.7	8.3	.083	5.2	.339
Toileting Ability	30.1	19.5	10.6	.029	4.0	.523
Stabilization of:						
Tissue Fluid Swelling	82.5	59.6	22.9	<.001	21.0	<.001
Grooming Ability	79.6	48.7	30.9	<.001	32.1	<.001
Katz Score	77.2	42.5	34.7	<.001	33.2	<.001
Social Participation	79.3	64.0	15.3	.017	32.2	<.001
Cognitive Ability	81.5	59.8	21.7	<.001	20.0	.001
Feeding Ability for Mildly Impaired Patients	76.6	64.1	12.5	.025	14.5	.025
Speech Problems	82.8	65.7	17.1	<.001	10.3	.041
Urinary Incontinence	81.3	67.1	14.2	.011	9.0	.141
Ambulation	73.4	62.4	11.0	.029	7.1	.177
Bowel Incontinence	83.0	69.3	13.7	.019	8.1	.232
Longitudinal Admission Sample						
Improvement in:						
Katz Score	33.3	22.6	10.7	.048	11.4	.037
Bowel Incontinence	36.1	19.3	16.8	.023	17.2	.041
Ability to Prepare Meals	15.5	6.0	9.5	.011	8.9	.047
Transferring Ability for Severely Impaired Patients	32.5	15.5	17.0	.040	15.0	.124
Grooming Ability for Mildly Impaired Patients	28.1	12.9	15.2	.023	4.5	.624
Toileting	31.7	21.5	10.2	.071	2.9	.692
Stabilization of:						
Tissue Fluid Swelling	87.2	62.3	24.9	<.001	27.0	<.001
Speech Problems	88.7	68.9	19.8	<.001	15.3	.005
Comprehension Problems	87.2	75.8	11.4	.040	14.5	.032
Katz Score Index	53.5	40.0	13.5	.064	11.9	.120
Ability to Use Telephone	67.1	51.5	15.6	.039	8.1	.310

EXHIBIT D

TABLE 1

PERSPECTIVES ON SUBACUTE CARE DEMONSTRATION

HCFA	HOSPITALS
cost-effective, budget neutral	placement of subacute care patients
decreased hospital admissions	increased revenues
focus upon quality of care and access to care	use of existing capacity, resources
optimal use of capacity	PR re: discharge, transfers, continuity of care
quality of long term care	stabilization of staffing
alternative payment systems	cost-based reimbursement, recovery of costs
interest in subacute care	quality of care
health policy directions	reduction of transfer trauma
increased knowledge re: effectiveness of medical services	medical backup
generalizability, replicability	screening capabilities, triaging of patients
save dollars: lowered readmission rates substitute effect (admit to subacute care directly) minimize nursing home placements avoid ICF placements	short-term assessment, monitoring
enhance quality outcomes for subacute care patients with rehab potential	development of comprehensive systems of care

TABLE 2

DEMONSTRATION DESIGN PARAMETERS

Number of test sites (evaluation and control)

- o greater Dayton area, greater Cincinnati area
- o other sites as needed

Number of hospitals (evaluation and control)

- o participating hospitals
- o non-participating hospitals (control group)

Reimbursement mechanism

- o hospitals
- o physicians

Eligibility criteria for patients

Definition of subacute care as separate class of patient

Number of hospital beds to swing

- o how many per hospital
- o which beds

Nature of physician involvement

Staging and implementation

- o by hospital unit
- o by specific beds
- o education of staff, patients, physicians

Orientation of staff, hospitals, patients, etc.

Extent to how "subacute" is defined

- o retroactively
- o prospectively

Participation by payers

TABLE 3

SUBACUTE CARE DEMONSTRATION

PATIENT FLOW CHART

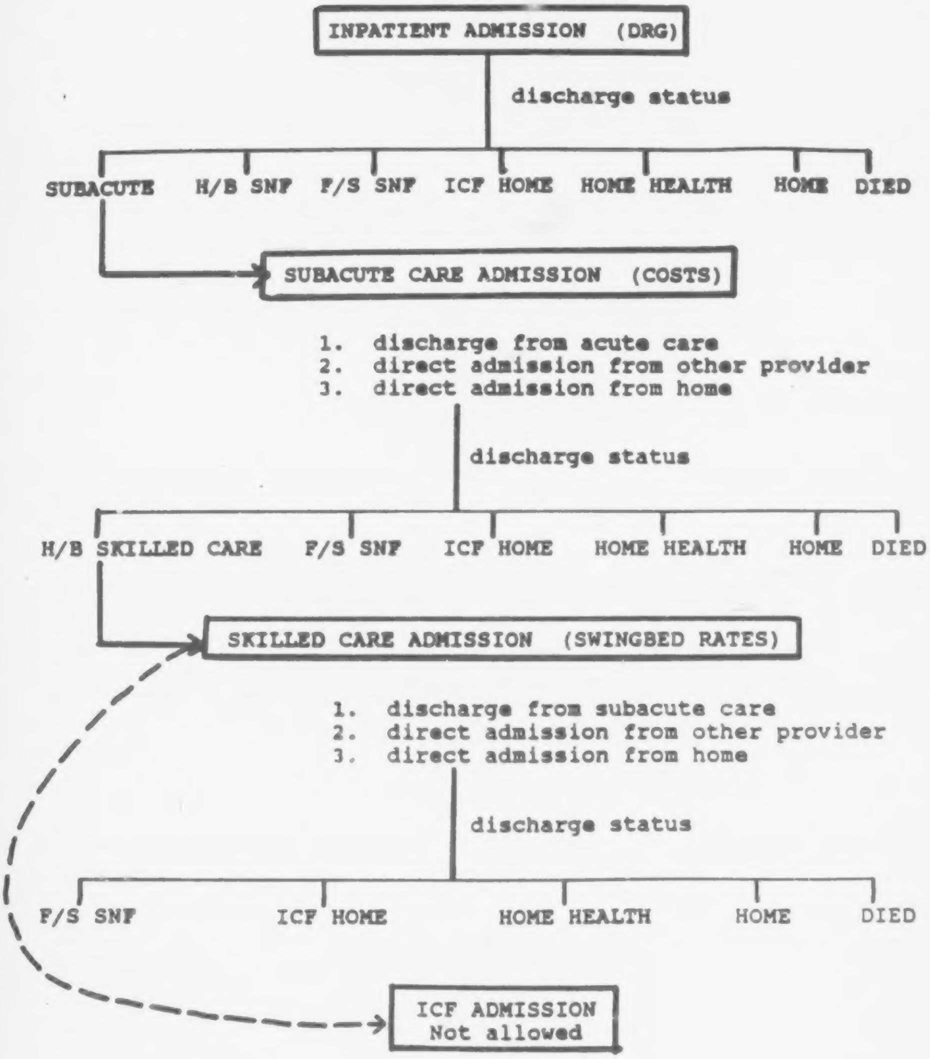
INPATIENT ADMISSION (DRG)
discharge status
SUBACUTE
H/B SNF
F/S SNF
ICF HOME
HOME HEALTH
HOME
DIED
SUBACUTE CARE ADMISSION (COSTS)
1. discharge from acute care
2. direct admission from other provider
3. direct admission from home
discharge status
H/B SKILLED CARE
F/S SNF
ICF HOME
HOME HEALTH
HOME
DIED
SKILLED CARE ADMISSION (SWINGBED RATES)
1. discharge from subacute care
2. direct admission from other provider
3. direct admission from home
discharge status
F/S SNF
ICF HOME
HOME HEALTH
HOME
DIED
ICF ADMISSION
Not allowed

TABLE 4

REIMBURSEMENT PROPOSAL FOR SUBACUTE CARE DEMONSTRATION

SUBACUTE CARE

- Part A, reasonable costs for life of project
- Part B, reasonable costs
- Physician payment, not affected
- UB-82 billing form

SKILLED CARE

- Swingbed reimbursement on admissions at this level
- May limit direct admissions at this level

INTERMEDIATE CARE

- Not allowed unless State Medicaid Program participates

PHYSICIAN PAYMENT

- Not changed
- Data collection used to support change in physician payment system for subacute care

TABLE 5

DESIGN PARAMETERS

ELIGIBILITY CRITERIA FOR PATIENTS

- no pre-hospitalization requirement
- medically stable, care unstable
    - complex care requirements
    - condition requires monitoring over 24-hour shift
    - minimum of 5 patient care hours per day (mixed staff)
- including:
    - Medicare
    - Medicaid (if approved)
    - Private Pay
    - Commercial Payers
- equipment as indicator of subacute care:
    - high technology
    - frequency of assessment
    - physician/staff involvement
    - lab monitoring
- medical diagnosis

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August 31, 1989

Mr. Edward F. Howard, Esq.
General Counsel
Pepper Commission
140 Cannon House Office Building
Washington D.C. 20515

FEDERAL EXPRESS

Dear Mr. Howard:

We are writing in regard to the hearings held by Congresswoman Mary Rose Oakar on behalf of the Pepper Commission in Cleveland on July 6, 1989. We would like to voice the concerns of other members of the health care delivery system that were not present at this hearing or other hearings being held by the Pepper Commission.

Self-Funded Plans, Inc. (SFPI) is a third party administrator (TPA) of self-insured employee benefit plans. The benefits administrered by SFPI include medical, dental, vision, drug, short and long term disability, and cafeteria plans. We work with over 200 employers ranging in size from 25 to 2,000 employees. These employers include municipalities, auto dealers, manufacturing, and national retailers. The plans administered by SFPI cover over 35,000 employees plus their dependents, and paid out over $51,000,000 in claims in 1988. Working with this many employers we see the problems that all employers face in providing a quality benefit program in a time of spiraling costs.

SFPI is also a member of the Society of Professional Benefit Administrators (SPBA). SPBA is an association of over 400 TPA's representing the entire nation. SPBA has worked closely with Congress and government agencies in regard to employee benefit issues. TPA's are unique in that they work with every part of the health care delivery system on a daily basis. Insureds, employers that sponsor plans, insurance companies, doctors, hosptials, lawyers and any other segment of the health care delivery system all at one time or another will deal with a plan administered by a TPA, and most likely that TPA is a member of SPBA.

SPBA did send a letter requesting that members of SPBA located in Cleveland be considered to testify before the Commission. While none of these persons were chosen the responsibilty to provide our thoughts to the Commission is not diminished.

Many ideas are being considered in meeting the problem of providing insurance for the estimated 37 million uninsured. These range from requiring employers to provide a minimum benefit to the government setting up a national health care program. A major consideration of the Commission should be to maintian freedom of choice for all those involved in the system. Individiuals should be given the freedom to choose the doctors they want to be treated by, whether this is through an HMO, PPO, or the traditional indemnity plan. Employers should also be given the choice of being fully insured or self-insured, and of what insurance companies and/or administrators to deal with.

Taking away the choices currently available lessens competition which leads to increased costs. There will be no incentive for insurance companies to develop new products for group coverage, or for doctors to develop new procedures if the entire system in controlled by rigid guidelines.

With this in mind we would like to address some of the issues raised at the July 6, 1989 hearing and add some of our own insights to the proposals that have been discussed.

During the July 6 hearing the Canadian system was mentioned by a number of people who testified. The mention of the Canadian system produced a great deal of applause from the crowd. Many people look to the Canadian system as the solution. If these people knew of the problems that the system is facing they might reconsider their opinion. While there are positives to the Canadian system the Commission must also carefully review the problems the Canadian system has experienced. If the Canadian system is copied we will experience the same problems.

Many proponents of the Canadian system point to greater access to care as a major advantage of the system. In reality access to care is being diminished in Canada due to the rationing of medical care. The denial of care to save money as a result of government intervention is evident in the Canadian System in the following ways:

> Toronto Orthopaedic and Arthritic Hospital had to cut the number of surgeries performed causing a two year delay.
>
> Ontario eliminated 300 medical residencies over the next five years. This will reduce access in the future.
>
> The sick and injured often wait for days in a hospital corridor until a space can be found for them.
>
> Quebec has imposed a limit on how much a doctor can bill the health insurance plan in any given year. The physicians are paid quarterly. Once the quarterly limit is reached many of the doctors go on vaction creating less access.
>
> Many nurses are quitting their jobs and are moving to the United States.
>
> Shortage of hospital beds.

> Many patients are coming to the United States to receive treatment that they would have to wait for in Canada. Facilities are being built in the United States to perform catscans for Canadians who would otherwise have to wait months to recieve them under the Canadian system.

Many people also think that the Canadian system provides free care. This is a misconception. The Canadian system does not cover all medical costs, such as prescription drugs and semi-private hospital rooms. Ninety-five percent of employers stepped in to provide some form of supplementary coverage.

The system has created an attitude where the Canadians do not expect to pay a cent for medical care. This attitude, which was apparent at the July 6 hearing must be addressed by the Commission. Providing first dollar health benefits will lead to over-utilization and increased costs. Participants in the plan must have some idea as to the cost of providing their health insurance. This can be accomplished through premium payments, deductibles, and co-insurance. By retaining these features a person must think about the cost before rushing to the hospital or doctor for every minor scrape of bruise. Obviously this would not deter anyone from seeking medical help when needed. These features must be maintained otherwise there will be no mechanisms to control costs.

The Canadian system has its problems, and is not our cure-all. Both Canada and the United Kingdom are confronting serious problems in the quality of care and providing affordable access to care. The Commission should look at building on the foundation of the current health care delivery system, using some of the positives of other systems and other ideas to strengthen and expand the current system. This would be preferable to copying a system that is experiencing major problems. .

The Commission should look at the problems small employers face in providing benefits to their employees. Testimony at the July 6 hearing showed that the majority of employers provide some benefits for their employees. It is the small employer (25 employees and below) that has the hardest time providing benefits. The reason cited for not providing benefits is cost. The cost for a small group is increased because of medical underwriting of small groups and because of economies of scale. If rules were relaxed to allow employers to form Multiple Employer Trusts (MET) and association groups small employers could band together to provide benefits. Providing incentives to insurance companies to pursue this type of business would also help.

Another problem facing the small employer is the different tax treatment of benefit plans. Many small employers are sole-proprietorships or partnerships. Under current tax law they can only deduct 25% of the cost of the health insurance provided to themselves. This is another factor that may discourage small employers from providing benefits.

Making it easier for employers to form METs, and giving insurers incentives to provide insurance for smaller groups would open up the benfit world to smaller employers. This would make a signifigant cut into the number of uninsured.

We must provide incentives for employers to provide benefits to their employees. Correcting the inconsistent tax structure mentioned above is only a beginning. If it is made easier for small employers to provide coverage then the commission should consider taxing employers that do not provide some form of basic benefits. The tax revenues should be earmarked to establish a risk pool that would provide coverage for the uninsured.

Another option is to mandate state risk pools. Several states have established risk pools in the past few years. These risk pools are starting to provide insurance to persons who were previously uninsured. If a person cannot afford to participate in the risk pool a voucher system could be established that would provide them coverage. The system could be based on income and need.

Mandated benefits has also been proposed as a solution to the problem. While we cannot say we would support mandated benefits as is currently being proposed the idea has many positive points, but if a system of mandated benefits is established incorrectly it would prove to be inefficient and would lead to increased costs.

At the July 6 hearing the Council of Smaller Enterprises (COSE) testified as to their sucess with their benefit plan. One point brought out in their testimony is that it has been estimated up to 10% of the cost of their plan is caused by state mandated benefits. These benefits are usually pushed through the legislature by special interest groups that want to require their services be covered under insurance plans. These benefits must be included in a fully insured plan whether the employer wants to provide a particular benefit or not. Self-insured plans are not effected by state mandated benefits because of ERISA pre-emption. Our clients have experienced cost savings by being able to customize their plan, including benefits that the employees have asked for and benefits that are not mandated by the state.

Mandating specific benefits (well-baby care, mental and nervous, chiropractic) will lead to the formation of a plan that is overtly influenced by special interest groups trying to get their piece of the pie. As members of COSE testified they have been sucessful with their plan. This sucess includes containing costs while providing quality benefits to plan participants.

In considering some form of mandated benefit system the Commission should maintain the framework of the current system, wherein employers still have a choice in how they will provide benefits to their employees. If choice is taken away from employers inefficiency and costs will continue to increase and an entire new series of problems will need to be addressed.

This issue is too large for any one Commission to handle or for one letter to cover. We hope this letter raises points that will be considered by the Commission. We also want to let the Commission know that we are ready to provide statistics regarding the plans we administer. As a TPA we have a unique perspective of the benefits world, it is this perspective that we feel can be of great service to the Commission in forming a plan to tackle the problem of the uninsured in America.

Please feel free to contact either of the undersigned to discuss points raised in this letter or other areas of concern to the Commission.

Very truly yours,

Richard C. Sheldon

Richard C. Sheldon
Executive Vice President

Brian D. Schorr

Brian D. Schorr
Director of Legal Services

cc: Members of the Pepper Commission
Fred Hunt, President, SPBA
Donna B. Luby, President Self-Funded Plans, Inc.

To Bi-partisan Commission on Comprehensive Health Care
Attention of The Honorable Mary Rose Oakar and
Ohio Long Term Care Action Network.

From Sister Ruth Kerrigan, M.S.N., R.N.

I have been teaching Home Nursing and Home Health Aides as a volunteer instructor with The Greater Cleveland Chapter ofthe American Red Cross for twenty-eight years. My full time employment has been teaching beginning baccalaureate nursing students for thirty five years.

My concern is the lack of available training or educational programs for the preparation of home health aides. The adequacy of the few available programs is of even greater concern. Most home health aides have no supervision and often no one to even give them advice on care needs of their clients.

There are no generally accepted national training programs for the preparation of home health aides and the State of Ohio is one of several states with no regulations for the training and supervision of home health aides. Currently there is pending legislation in Ohio for the training and supervision of nursing assistants in nursing homes. At least in a nursing home there is someone to consult with in relation to care of residents.

I would like to recommend The AMERICAN RED CROSS BE GIVEN THE RESPONSIBILITY OF PREPARING AND IMPLEMENTING A COURSE FOR THE CARE OF THE SICK AND DISABLED IN THEIR HOME. THIS COURSE SHOULD BE USED NATIONWIDE AS THE BASIC PREPARATION OF HOME HEALTH AIDES AND HOME CARE GIVERS.

IN 1913 the American Red Crosspublished the first edition of Elementary Hygiene and Home Care of the Sick. Down through the years to the present time the book has been revised and used by the Red Cross, public health nursing services, schools, colleges and other groups in teaching family health and home nursing.

It seems appropriate that the Red Cross be given this responsibility as the Red Cross has had responsibility for First Aid and Water Safety on the national level working with labor, industry and all levels of formal educational institutions.

Sr. Ruth Kerrigan CSJ
5232 Broadview Rd
Richfield Oh. 44286
(216) 657-[illegible]

MARYMOUNT

Marymount Hospital
12300 McCracken Road
Garfield Heights, Ohio 44125-2975
Telephone 216 581 0500

July 6, 1989

The Honorable Mary Rose Oakar
Member of Congress
Pepper Commission on Comprehensive Health Care
U.S. House of Representatives
523 Federal Court Building
215 Superior Avenue
Cleveland, Ohio 44114

Dear Congresswoman Oakar:

I am writing on behalf of Marymount Hospital and a very unique endeavor that we are about to become a part of with the Commonwealth Multiple Employer Trust (M.E.T.) Administrators, Inc.

We applaud the efforts of the Pepper Commission whose principal focus is to address the concern that the U. S. Bipartisan Commission has identified, namely, "the problems of the 37 million Americans lacking health insurance--23 per cent of whose breadwinners work for small businesses".

The concept is a simple one, namely the design of Local Health and Welfare Benefit Trusts that includes significant participation by those groups to be covered by the Trust. Provider inclusion is competitively bid and selected upon price and quality of services with, again, user participation in decisions related to the array of services and the providers of same.

I would cite as a local success story the Lake County Employer Benefit Trust, which became operational last year. I submit for your consideration that this concept is one which has the potential to be expanded not only in Northern and Northeastern Ohio, but also across the country, and one which warrants consideration by this Commission. If your Commission is so inclined, I would be pleased to provide you with additional information on this concept and how same may be considered as a contrasting option to the C.O.S.E. Plan, which has a heavy insurer involvement and, resultantly, a profit motive that needs to be satisfied at the potential deficit of services to those you are looking to cover.

Again, thank you for your continued support of Marymount Hospital and for your concern relative to the Health Insurance Problems of Small Businesses and Employees.

Sincerely,

Thomas J. Trudell
President and
Chief Executive Officer

*A total health care system
conducted by the Sisters of St. Joseph
of the Third Order of St. Francis*

VHA
Member of Voluntary Hospitals of America, Inc.

*What makes us different
is what makes us better*

○ A member of the
Emerald Health Network

Statement of International Association of Machinists and Aerospace Workers - District 54 Retirement Club of 2906 Euclid Avenue of Cleveland, Ohio 44115

As a Business Representative of the I.A.M. + A.W. for 21½ years, retiring on July 1, 1978, and as President of the Machinists Retirement Club in Cleveland, Ohio, I am presenting the views of our members as expressed at our regular monthly meeting of June 25, 1989.

We believe that a comprehensive health care system, patterned after that of Canada is the solution to overcoming the catastrophe which exists in the health care system of our country which is the only nation of any consequence in the world without national health care. Unfortunately we are in the same category as South Africa in that regard.

In Canada through efficient administration, cost containment and control of the purchase and sharing of the expensive medical equipment they are able to provide adequate health coverage for all with an expenditure of around 8% of its GNP while we with 12% have over 37 million without any coverage at all and additional millions with inadequate care.

It is a national disgrace that even employees in hospitals and health centers have had to and are finding it necessary to resort to strike action to gain and maintain for themselves and their familie's the very same services they work at. We have had several such cases in our city in recent months.

The strikes in our IAM District in recent months have had the matter of health benefits and payment of the premiums as the main item of disagreement.

Our organization is also of the opinion that as Canada began its system in three of its provinces, we begin here in Ohio with UHIO (Universal Health Insurance for Ohio) by adopting HB 425 which is in sub-committee hearings in Ohio.

It is our opinion that a great injustice exists when the legislators some of whom oppose national health care for others, are fully covered while people who are unable to show the ability to pay for their care, are not admitted in many hospitals even in emergency situations.

We respectfully urge this Commission to do all in its power to get health care for all enacted without any further delay.

Thank you.

Sincerely
Walter Dalasz, President
4030 Silsby Rd., University Hts.,
Ohio 44118

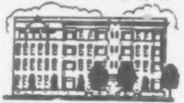
HELP HOUSING FOR THE DISABLED • HELP SUMMER PROGRAM
JOINT INDEPENDENT LIVING PROJECT • SEMI INDEPENDENT LIVING PROGRAM
NOTTINGHAM HOME

HELP, INC.

HELP HOME FOR RETARDED CHILDREN

HELP FOUNDATION, INC.
4614 Prospect Avenue, #324
Cleveland, Ohio 44103 (216) 432-4810

HELP - SIX CHIMNEYS, INC.



INDEPENDENT APARTMENT LIVING FOR
THE DEVELOPMENTALLY DISABLED

July 14, 1989

Representative Mary Rose Oakar
Capital Hill Office
2231 Rayburn House Office Building
Washington, D.C. 20515

JUL 19 1989

Re: Comprehensive Health Care -
Habilitation Center Funding

Dear Representative Oakar:

We are grateful for the opportunity to provide the enclosed written testimony for the official record generated by the Pepper Commission on Comprehensive Health Care (see Exhibit A). The health issues which were the subject of your July 6, 1989 hearing in Cleveland, Ohio, are of particular interest to Ohio citizens. Furthermore, the "challenge of providing long-term care services for the . . . disabled" is Help's sole reason for existence.

Help is a private, non-profit organization which provides residential, training and rehabilitation programs to children and adults with mental retardation and developmental disabilities. In existence since 1965, it has served hundreds of the mentally retarded/developmentally disabled ("MR/DD") in Cuyahoga County. Help offers community-based residential facilities, including group homes and independent living apartments; it also provides a variety of support/training services to the disabled.

Help's efforts have been hindered by a lack of adequate funding, barriers to accessing services and benefits, and discrimination. Indeed, Help has expended much time, energy and money over the past 18 months battling the third of these obstacles - discrimination. It is appropriate, at this time, to bring you up to date on Ohio's struggle to provide habilitation services to its MR/DD citizens.

In 1986, after a legal battle which reached the Sixth Circuit Court of Appeals, the Health Care Financing Administration ("HCFA") approved Ohio's Amendment to its Medicaid Plan, pursuant to which habilitation services would be provided to the MR/DD community. Upon receipt of Ohio's claim for

NON-SECTARIAN • NON-PROFIT • TAX-EXEMPT
COMPREHENSIVE SERVICES FOR THE DEVELOPMENTALLY DISABLED

previously rendered services, however, HCFA not only challenged Ohio's right to the reimbursement claimed but also initiated a further challenge to Ohio's Amendment. The end result is that, to date, three years after HCFA's approval of Ohio's Amendment and seven years after habilitation services were first provided to Ohio's MR/DD citizens, HCFA has paid a mere fraction of what is owed under Medicaid for the services rendered.

Help has filed a complaint charging discrimination under §504 of the Rehabilitation Act. Enclosed as Exhibit B is a copy of the April 4, 1989 letter from Help's attorney outlining the basis for that complaint. Unfortunately, although that complaint on June, 1988, the HHS Office of Civil Rights has not yet completed its investigation.

To compound the problem, HCFA has insisted (without any support in the federal statutes, federal regulations, or HCFA's formal policies), that habilitation services will be reimbursed under Medicaid only if rendered to residents of intermediate care facilities serving the MR/DD community or pursuant to a home and community based waiver program. Indeed, when Ohio challenged this stance and reminded HCFA that programs similar to Ohio's had been approved in other states, HCFA began a national effort to curtail these much-needed services. Enclosed as Exhibit C is the March 17, 1989 letter from the Consortium for Citizens with Disabilities to Louis Sullivan, Secretary of HHS, evidencing the national scope of HCFA's discrimination.

Help and the MR/DD community which it serves urges your support of H.R. 854, the "Medicaid Community and Facility Habilitation Services Amendment", which presents a long-term solution to the discrimination currently being suffered by the mentally retarded and developmentally disabled citizens across the country. This legislation allows the states, at their option, to offer a wide range of habilitation services in both community and institutional settings. Consequently, we believe it will defuse HCFA's current challenge to such services.

Again we thank you for the opportunity to provide you with this information. We appreciate your interest in the right of the disabled to long-term care services.

Very truly yours,

Walter I. Zborowsky
Walter I. Zborowsky

WIZ/bbz

Enclosures

cc: Ms. Carol I. Peck
William D. Ginn, Esq.
Virginia S. Brown, Esq.
Elizabeth B. Wright, Esq.

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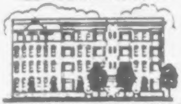

INDEPENDENT APARTMENT LIVING FOR
THE DEVELOPMENTALLY DISABLED

Written Testimony for the Official Record
Pepper Commission on Comprehensive Health Care
Hearing Held in Cleveland, Ohio on July 6, 1989

Re: Health Care Services for the Disabled

Responsibility for the Medicaid Program in Ohio is lodged with the Ohio Department of Human Services ("ODHS"). Despite Ohio's Amendment to provide community-based habilitation services to the MR/DD population, and despite HCFA's 1986 approval of Ohio's Amendment, HCFA has rendered that Amendment impotent by its refusal to make Medicaid reimbursement for such services. In late 1988, HCFA and the State of Ohio reached an agreement pursuant to which HCFA paid a $30 million "draw" and permitted the State of Ohio until June 30, 1989 to file a final claim for restitution. If the final claim is less that $30 million, Ohio must pay the excess to HCFA; if the final claim is more than $30 million, HCFA is to make an additional payment. Notwithstanding this agreement, however, the cost of the habilitation services rendered to Ohio's MR/DD citizens since 1982 (the effective date of Ohio's Amendment) is approximately $300 million. Thus, HCFA's $30 million payment is a mere fraction of what it has cost Ohio to serve its MR/DD citizens.

To compound the problem, HCFA has unilaterally and arbitrarily determined that habilitation services may be reimbursed under Medicaid only when provided to residents of intermediate care facilities serving the MR/DD community or pursuant to a home and community-based waiver program. There is nothing in the federal statutes, federal regulations or even HCFA's formal policies which supports HCFA's position.

When Ohio challenged HCFA's position by identifying other states which currently provide habilitation services to clients living in the community, HCFA responded by initiating a national effort to disallow those other programs. Thus far, Maine and Arkansas have received disallowance letters; Vermont and New Hampshire have acceded to HCFA's unilateral (and unsupportable) demand by transferring their habilitation services program to a home and community based waiver; Massachusetts is being audited; and other states which currently provide day habilitation services are justifiably concerned about the security of their programs.

Exhibit A

NON-SECTARIAN • NON-PROFIT • TAX EXEMPT
COMPREHENSIVE SERVICES FOR THE DEVELOPMENTALLY DISABLED

Help and its affiliated agencies urge support of the Medicaid Community and Facility Habilitation Amendments of 1989 (H.R. 854), which would allow states, at their option, to provide a range of habilitation and supportive services in the community to Medicaid-eligible individuals with mental retardation or developmental disabilities.

The challenge of providing long-term care services for the disabled has been made vastly more difficult by HCFA's refusal to permit Medicaid reimbursement as broadly as permitted under the federal law and federal regulations. Its arbitrary and unilateral actions, taken to thwart the provision of habilitation services across the country, must be stopped if the disabled are to receive the long-term care services to which they are entitled.

Respectfully submitted,

Walter I. Zborowsky

Walter I. Zborowsky

Dated: July 14, 1989

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WRITER'S DIRECT DIAL NUMBER
216-566-5754

April 4, 1989

Ms. Patricia Lucas - Compliance Supervisor
U. S. Department of Health
and Human Services
Office of Civil Rights
105 West Adams - 16th Floor
Chicago, Illinois 60603

Re: Ohio's Plan for Habilitative Services

Dear Ms. Lucas:

In response to your inquiry to both Walter Zborowsky and me, the following will further detail Help, Inc.'s complaint filed as a result of the discrimination by the Chicago Regional Office of HCFA against the mentally retarded and developmentally disabled citizens of Ohio.

By way of brief background, the State of Ohio amended its Medicaid State Plan in March, 1982 to provide coverage of developmental services for the mentally retarded and developmentally disabled. HCFA refused to approve the amendment, with the concurrence of the Secretary of HHS. Ohio filed an action in the Sixth Circuit Court of Appeals for a review of HCFA's position. In May, 1985, the Sixth Circuit found that the parties' disagreement over "rehabilitative" as opposed to "habilitative" services had blinded them to the real issue and remanded the proceeding to provide Ohio with the opportunity to demonstrate that the services in question constitute "medical assistance" as defined in Title XIX.

Over the next year, HCFA and Ohio discussed the services for which the State sought coverage. Finally, in May, 1986, HCFA approved Ohio's Amendment 82-14 (see Exhibit A). Under that amendment, rehabilitative/habilitative services which are in furtherance of a treatment plan designed by a licensed professional are covered. Bear in mind that the amendment did not seek coverage for educational, vocational, pre-vocational or socialization services. Rather, it included those developmental services which enable a mentally retarded or developmentally disabled person to live independently in the community. The

Exhibit B

amendment made no distinction between community clients and ICF/MR residents. Nor did it require that the services be rendered directly by a licensed professional.

The services included in Ohio's amendment are those necessary to carry out a treatment program developed by a licensed professional (such as a doctor, nurse, occupational therapist, physical therapist, psychologist and/or speech therapist). The services include, for example, behavior management and personal hygiene. By way of illustration, a developmentally disabled person with trouble walking would work with a direct care worker, who would assist the client with a regimen designed by an occupational or physical therapist. Because repetition is very often the key to success with these kinds of developmental services, they are often prescribed on a daily basis, and sometimes more frequently.

After Ohio submitted its claim for services rendered from 1982 through May, 1986 (which totalled over $290 million), HCFA began its attempts to narrow the coverage provided under Ohio's amendment and, simultaneously, refused to make payment for either pre- or post-May, 1986 services. It requested voluminous documentation from the State and, as the documents received under the Freedom of Information Act ("FOIA") reveal, employed all manner of manipulation to force Ohio to revise its amendment.

In September, 1988, after the documents obtained under FOIA were examined in detail, HCFA and the State renewed their efforts to resolve this dispute. With respect to restitution for services rendered from 1982 through June 30, 1988, HCFA has paid a "draw" of $30 million. Ohio has until June 30, 1989 to make its final claim for services rendered before June 30, 1988. HCFA has insisted that the State seek reimbursement only for services provided to ICF/MR and nursing home residents during the restitution period. If the State's final claim for services exceeds $30 million, HCFA shall authorize an additional payment. If it is less than $30 million, the State shall return to HCFA the excess. (See Exhibit B.)

In additional, HCFA has advised Ohio of revisions which must be made to the amendment for rehabilitative/habilitative services in order to receive reimbursement for services rendered after June 30, 1988. Specifically, HCFA has stated that it will not approve reimbursement for habilitation services rendered to community clients unless they are rendered directly by a licensed professional. Not only does this dramatically reduce the scope of Ohio's amendment as approved in 1986, but it is also blatantly discriminatory. If those same services are provided to a mentally retarded or developmentally disabled person by a direct care worker in an ICF/MR (pursuant to a plan developed by a licensed professional), they are reimbursable. Yet for a mentally retarded or developmentally disabled individual residing at home, they are not.

HCFA has clearly ignored the federal statutes entitling the handicapped to services rendered in the least restrictive environment, because it has in essence forced a mentally or developmentally handicapped person to be institutionalized before these services can be covered. Remember that these services are covered for community clients only if provided directly by a licensed professional. It is ludicrous to believe that the licensed professionals can, in fact, provide these habilitative services in a meaningful manner to all of the mentally retarded and developmentally disabled citizens living in the community.

The restriction imposed by HCFA in the MR/DD setting is absent elsewhere. For example, the elderly, the mentally ill, stroke victims and accident victims receive habilitation/rehabilitation services, reimbursable under Medicaid, provided by a direct care worker as opposed to directly by a licensed professional, regardless of whether they live in the community or reside in an institution.

The following hypotheticals illustrate the discrimination evident in HCFA's position. A mother of a developmentally handicapped child may take her child to a Habilitation Center for speech therapy. A child residing in a ICF/MR is taken to the same Center for the same speech therapy. Both receive therapy from a direct care worker pursuant to a plan designed by a speech therapist. Yet only the services rendered to the ICF/MR resident are reimbursable. Similarly, a stroke victim, residing at home, may visit the same Center for speech therapy by the same direct care worker. Those services, too, are reimbursable under Medicaid. The discrimination against mentally retarded and developmentally disabled residing in the community is undeniable.

As I mentioned during our telephone conversation, HCFA's reversal of its position and refusal to make payments under Ohio's amendment approved in 1986 has had severe consequences. Although I am not privy to documentation of these facts, it is my understanding that most of the habilitation service providers simply stopped billing and some providers stopped supplying these services to the MR/DD community. In addition, the lack of reimbursement inhibited any expansion of the programs for habilitation services because the providers were paying the federal share out of their own budgets and simply could not afford it. Thus, the waiting list of individuals needing habilitation services has grown.

New York, Idaho and Michigan have provided habilitation/rehabilitation services to community clients since at least 1986. In fact, New York's program was instituted in 1978. Michigan's plan was urged on Ohio by HCFA as a model, not to limit, restrict or define the services but as a guide for reimbursement methodology. (See Exhibit C.) In July, 1988, the State of Maine expanded its program with HCFA's approval to include community clients. In December, however, HCFA retroactively disallowed that expansion after it was used by Ohio to illustrate HCFA's capricious treatment of Ohio's amendment. I do not have copies of the plans for these states, but I am sure you can get them from HCFA, the Ohio Department of Human Services, or the Ohio Department of Mental Retardation and Developmental Disabilities.

We received approximately 2,000 pages from HCFA under the Freedom of Information Act. I have enclosed herewith correspondence, inter-office memoranda and other pertinent documents. I realize this is a lot of material but I thought it best that you see the whole picture.

Thank you for your attention to this problem. Pleas call me if I can provide any additional information or be of assistance in furtherance of a prompt resolution of this serious situation.

Very truly yours,

Virginia S Brown

Virginia S. Brown

VSB/jl
Enclosures
cc: Ms. Marilyn Brusherd (w/o encl.)
Mr. Walter Zborowsky (w/o encl.)
Ms. Carol Peck (w/o encl.)
Mr. Robert Brown (w/o encl.)
Marty Ford, Esq. (w/o encl.)
William D. Ginn, Esq. (w/o encl.)
Elizabeth B. Wright, Esq. (w/o encl.)

Consortium for
Citizens with
Disabilities

Task Force on Medicaid
Long Term Care. Contact:

R. Gettings, NASMRPD - 683-4202
M. Ford, ARC/US - 785-3388
A. Bergman, UCPA - 842-1266

March 17, 1989

RECEIVED
APR 4 1989
DIRECTOR'S OFFICE
ODMR/DD

The Honorable Louis W. Sullivan
Secretary of Health and Human Services
Room 615F, Hubert H. Humphrey Building
300 Independence Avenue
Washington, D.C. 20201

Dear Secretary Sullivan,

As a coalition of organizations interested in the welfare of citizens with disabilities, we wish to congratulate you on your recent Senate confirmation as Secretary of Health and Human Services and call to your attention a serious problem surrounding Medicaid funding of day habilitation services for persons with developmental disabilities.

In a recent letter to state Medicaid commissioners in the New England states, Mr. Alfred G. Fuoroli, the Associate Regional Administrator of the Health Care Financing Administration in Boston, announced that his office was initiating a region-wide review of Medicaid claims for federal financial participation in the cost of daytime habilitation services provided to persons with mental retardation and related conditions. Mr. Fuoroli indicated that the term "habilitation services" is defined in HCFA policy only in the context of intermediate care facility services for persons with mental retardation and home and community-based waiver services for such individuals. He went on to state that:

> Although some "habilitation services" (as an umbrella term) may be funded within the definitions of clinic services (42 CFR 440.90) and rehabilitative services (440.130(d)), there is no basis for funding specialized habilitative care designed to aid the development of the mentally retarded under the definitions of clinic and rehabilitative services, nor may clinic or rehabilitative services be targeted or limited to this population.

Since Mr. Fuoroli told the New England state commissioners that "similar reviews are.... being conducted by HCFA in other [HHS] regions", we must assume that Region I's interpretation of HCFA policy has been sanctioned by the Agency's central office staff in Baltimore. And yet, the position outlined above appears to be virtually identical to the one rejected by the Sixth Circuit Court of Appeals in a 1985 case involving the coverage of certain "rehabilitative services" for

Exhibit C

FORMERLY: CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

persons with developmental disabilities in Ohio. In this decision (State of Ohio, etc. v. HHS, No. 84-3181, filed May 17, 1985), which, by the way, HHS elected not to appeal, the Circuit Court ruled that Ohio may cover such specialized services under its Medicaid state plan but, because of the broad manner in which these services were described in the State's proposed plan amendment, the case was remanded to HHS for a determination of the precise scope of services that would be treated as Medicaid reimbursable. In arriving at its decision, the Court reached the following conclusions:

- Title XIX of the Social Security Act, since its inception, "...has authorized funding for rehabilitative services as well as medical services." Therefore, "on its face the plan amendment appears to propose the offering of services -- however denominated -- which fall within provisions of the Act."

- The term "rehabilitative services" is defined in HHS/HCFA regulations as "...any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level" (42 CFR 440.130(d)).

  In construing a federal statute, courts are required to defer to longstanding administrative interpretations; however, in the Ohio case, the Court concluded that:

  > ...there is no longstanding, consistent construction of the Medicaid Act which prohibits funding "habilitative services". So far as this record discloses, the issue has never been addressed by HCFA prior to this case. This being so, the issue is not so much one of deference as it is whether the agency's interpretation is consistent with congressional intent...

  The Court concluded that there was nothing in the Act or HCFA's published regulations that provided grounds for denying a state authority to cover habilitation services under the rehabilitative services plan option. As noted above, however, the Court did remand the case to the Secretary for a determination of the specific elements of services that would be treated as Medicaid allowable costs.

Although nearly four years have passed since the Six Circuit handed down its decision in State of Ohio, etc. v. HHS, it is our understanding that HHS/HCFA and the Ohio Department of Human Services still have not reached agreement on the types of "habilitation center" service costs that the State may claim as reimbursable "rehabilitative services" under its Medicaid plan. During the ensuing years, HHS/HCFA has published no modifications in its regulatory definition of coverable "rehabilitative services" or, to our knowledge, any further administrative interpretation of intent and scope of services fundable under 42 CFR 440.130(d). Indeed, HCFA's Medicaid State Operations

Manual is devoid of any instructions to the states on the circumstances under which a state may or may not claim reimbursement for habilitation services under 42 CFR 440.130(d). Certainly, we are aware of no statement in formal HCFA policies which indicates that "there is no basis for funding specialized habilitative care designed to aid the development of the mentally retarded under the definitions of clinic and rehabilitative services..." or that "...clinic or rehabilitative services" may not be "targeted or limited to this population", as asserted in Mr. Fuoroli's recent letter to the Medicaid commissioners in Region I states.

If the Department believes that a statutory basis exists for the interpretations contained in Mr. Fuoroli's letter, we would respectfully suggest that HHS/HCFA has a legal obligation under the Administrative Procedures Act to issue a Notice of Proposed Rulemaking spelling out its position and soliciting public comments on any proposed regulatory changes. Given the absence of any basis in written policy to support the interpretations contained in the recent Region I letter, it appears to us that the Department is in no position to claim that these interpretations are a reflection of longstanding HHS/HCFA policy.

Viewed from a broader perspective, this current situation illustrates more fundamental shortcomings in HHS/HCFA's procedures for developing and articulating Medicaid policies as they impact on the provision of long term care services to persons with developmental disabilities. First, the present controversy surrounding Title XIX claims for day habilitation services underscores the urgent need to reformulate Medicaid laws governing the financing and delivery of services to this population. Now that the emphasis in the field of developmental disabilities has shifted to the provision of residential, training and support services in home and community-based settings, it makes no sense to limit Medicaid financing options primarily to institutional services. Major bills are currently pending in both the Senate and the House of Representatives to eliminate this institutional bias of present Medicaid policy (S. 384; H.R. 854). Under your leadership, we hope that the Department, in particular, and the Bush Administration, in general, will support efforts now underway in Congress to provide a more reliable statutory basis for supporting community-based long term care services for children and adults with developmental disabilities.

Second, the lack of a clear set of administrative policies governing the provision of Medicaid-reimbursable day habilitation services is symptomatic of the fragmented manner in which developmental disabilities policies are formulated within the Department. In our opinion, the Department lacks a consistent set of policy goals and an administrative structure that is amendable to pursuing such goals. As a result, administrative policies tend to be made in a piecemeal fashion, with little relationship to whether they reinforce or impede current state-of-the-art practices in serving persons with severe, lifelong disabilities.

A related problem is the cumbersome process of preparing, reviewing and publishing HHS administrative rules. Due to the complex series of clearances required, it often takes years to issue critical rules and, not infrequently, the publication of necessary regulations end up being postponed indefinitely. Rules governing the circumstances under which Medicaid reimbursement is available for rehabilitative services is a case in point. To our knowledge, HCFA (or its predecessor agencies) has actively considered the development of revised rehabilitative services rules on several occasions -- beginning as long ago as the mid-1970's. Unless methods can be found to streamline the present administrative rulemaking process within the Department, controversies similar to the current situation surrounding Medicaid payments for day habilitation services will continue to arise. One positive step in this direction would be to involve interested outside organizations such as ours at the front-end of the rulemaking process, rather than relying solely on the formal public comment period to obtain feedback from affected interest groups.

We recognize that you will face many challenges as you assume your new duties. For our part, we look forward to working with you to improve the effectiveness and responsiveness of all HHS's programs for assisting persons with disabilities.

Sincerely yours,

Marty Ford	Allan Bergman	
Martha Ford Association for Retarded Citizens, United States	Allan Bergman United Cerebral Palsy Associations, Inc.	Robert M. Gettings National Association of State Mental Retardation Program Directors

On behalf of:

American Association of University Affiliated Programs
American Coalition of Citizens with Disabilities
American Foundation for the Blind
American Occupational Therapy Association
American Speech-Language-Hearing Association
Association for Persons with Severe Handicaps
Association for Retarded Citizens
Epilepsy Foundation of America
National Alliance for the Mentally Ill
National Association of Developmental Disabilities Councils
National Association of Music Therapy
National Association of Private Residential Resources
National Association of Protection and Advocacy Systems
National Association of State Mental Health Program Directors
National Association of State Mental Retardation Program Directors
National Easter Seal Society
The Association for Persons with Severe Handicaps
Tourette Syndrome Association
United Cerebral Palsy Association

cc: Senator Mitchell
Senator Bentsen
Representative Dingell
Representative Waxman